DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Resource Based Relative Value Scale (RBRVS) Users:
- Anesthesiologists
- Advanced Registered Nurse Practitioners
- Emergency Physicians
- Family Planning Clinics
- Federally Qualified Health Centers
- Health Departments
- Laboratories
- Managed Care Plans
- Nurse Anesthetists
- Ophthalmologists
- Physicians
- Physician Clinics
- Podiatrists
- Psychiatrists
- Radiologists
- Registered Nurse First Assistants

Memorandum No: 05-59 MAA
Issued: July 1, 2005

For Information Call:
1-800-562-6188

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

Subject: Physician-Related Services: Corrections and Fee Schedule Updates

Effective for dates of service on and after July 1, 2005, the Medical Assistance Administration (MAA) will implement:

- The updated Medicare Physician Fee Schedule Data Base (MPFSDB) Year 2005 relative value units (RVUs);
- The updated Year 2005 Relative Value Guide base anesthesia units (BAUs);
- The updated Medicare Clinical Laboratory Fee Schedule (MCLFS);
- The updated Medicare Single Drug Pricer (SDP);
- A legislatively appropriated one (1.0) percent vendor rate increase; **AND**
- The technical changes listed in this numbered memorandum.

Below are MAA's July 1, 2005 conversion factors:

Title	Procedure Codes	July 1, 2005 Conversion Factor
Adult Primary Health Care	99201-99215	$24.82
Anesthesia		20.44
Children's Primary Health Care	99201-99215, 99431-99435, and 99381-99395.	34.56
Clinical Lab Multiplication Factor		.820
Maternity	58611, 59000, 59025, 59400-59410, 59425-59426, 59430, 59510-59525, 59610-59622.	44.99
All Other Procedures Codes	Except Clinical Laboratory	22.71

Maximum Allowable Fees

MAA has updated the fee schedule with Year 2005 RVUs, BAUs, clinical laboratory fees, and Single Drug Pricer (SDP) pricing. The 2005 Washington State Legislature appropriated a one (1.0) percent vendor rate increase for the 2006 state fiscal year. The maximum allowable fees have been adjusted to reflect these updates.

Injectable Drug Updates

MAA has updated the maximum allowable fees for those drugs listed in the injectable drug fee schedule. These fees are posted on MAA's website at http://maa.dshs.wa.gov (click on Provider Publications/Fee Schedules, then Fee Schedules). All fees have been updated at 106% of the Average Sales Price (ASP) as defined by Medicare. If a Medicare fee is unavailable for a particular drug, MAA will continue to price the drug at 86% of the Average Wholesale Price (AWP).

The following new injections require prior authorization (PA):

HCPCS Code	Brief Description	July 1, 2005 Maximum Allowable Fee
Q9955	Inj perflexane lip, micros ml	$13.25
Q9956	Inj octafluoropropane mic,ml	41.60
Q9957	Inj perflutren lip micros, ml	62.13

Diagnosis Reminder

MAA requires valid and complete ICD-9-CM diagnosis codes. When billing MAA, use the highest level of specificity (4th or 5th digits when applicable) or the services will be denied.

Bariatric Surgery Policy

MAA covers bariatric surgeries in MAA-approved hospitals for bariatric surgery in accordance with WAC 388-531-1600. **PA is required**. For details on PA, see section I.

After Hours

MAA's policy for after hours is defined as:

- The physician is called to come back to the office after leaving for the day; or
- Services received after regular clinic/office hours.

For example: If a clinic closes at 5 pm and takes a break for dinner and then opens back up from 6 pm-10 pm, these services are not eligible for after hours service codes.

☞ **Note:** This policy does not include radiologists, pathologists, emergency room physicians or anesthesiologists. After hours CPT codes are not covered for any of these specialties.

Internal Lab Code Pricing

Payment calculation for individual automated laboratory tests is based on the total number of automated multichannel tests performed per day, per patient. Reimbursement for each test is based on Medicare's fees multiplied by MAA's fiscal year laboratory conversion factor.

PET Scan Policy

MAA no longer accepts HCPCS codes for PET scans (except G0330 and G0331).

Providers must bill the appropriate CPT code for PET scans. MAA reimburses only for the following PET scan CPT codes: 78459, 78608, and 78811-78813.

All outpatient PET scans require some form of authorization. For details on PA and EPA see section I.

Radiopharmaceutical diagnostic imaging agents

Effective for dates of service on and after May 1, 2005, MAA pays providers for the following codes for radiopharmaceutical diagnostic imaging agents **without** PA:

Procedure Code	Brief Description
79101	Nuclear rx, iv admin
79445	Nuclear rx, intra-arterial
79905	Nuclear rx, oral admin

Contrast Material

MAA has adopted the following HCPCS codes to replace A4643-A4647:

HCPCS Code	Brief Description	July 1, 2005 Maximum Allowable Fee
Q9945	LOCM <=149 mg/ml iodine, 1ml	$0.26
Q9946	LOCM 150-199mg/ml iodine,1ml	1.65
Q9947	LOCM 200-249mg/ml iodine,1ml	1.31
Q9948	LOCM 250-299mg/ml iodine,1ml	0.29
Q9949	LOCM 300-349mg/ml iodine,1ml	0.35
Q9950	LOCM 350-399mg/ml iodine,1ml	0.24
Q9951	LOCM >= 400 mg/ml iodine,1ml	A.C.
Q9952	Inj Gad-base MR, contrast, ml	bundled
Q9953	Inj Fe-based MR, contrast, ml	bundled
Q9954	Oral MR contrast, 100 ml	bundled

MAA does not reimburse Q9952 through Q9954 separately.

Home Services

CPT codes 99341-99350 (Home Services) are only reimbursed in place of service 12 (home).

Therapeutic or Diagnostic Injections

MAA has adopted the appropriate HCPCS codes for therapeutic and diagnostic injections.

Do not bill CPT codes 90780 – 90788 in combination with HCPCS codes G0345 – G0353. MAA does not reimburse providers for CPT code 99211 on the same date of service as drug administration HCPCS codes G0345 – G0349, G0351 – G0353, and CPT codes 90780 – 90788. If billed in combination, MAA will deny the E&M code 99211. However, providers may bill other E&M codes on the same date of service using modifier 25 to indicate that a significant and separately identifiable services was provided. If modifier 25 is not utilized, MAA will deny the drug administration code.

Botulism Injections

MAA requires PA on Botulism injections (HCPCS codes J0585 and J0587) for all diagnoses.

Anesthesia Policy Clarification

When a planned vaginal delivery (CPT code 01967) is started and results in a cesarean delivery (CPT code 01968) or a cesarean hysterectomy (CPT code 01969), the services for these anesthesia codes are considered one procedure.

If an anesthesiologist and a Certified Registered Nurse Assistant (CRNA) are both involved in this procedure, they must each bill the above procedure codes utilizing modifier QX (CRNA SVC W/ MD MED DIRECTION) and QY (MEDICALLY DIRECTED CRNA).

If a CRNA is not involved, the anesthesiologist must bill for both procedure codes utilizing modifier (AA).

Trauma Section Updates

The contact for reimbursement questions for trauma services has changed. The correct contact person is:

Larry Linn, Hospital Rates Manager
Medical Assistance Administration
Hospital/Managed Care Rates Section
(360)-725-1834

Cochlear Implants Update

MAA has adopted the following HCPCS codes for replacement parts for cochlear implants: L8615-L8622. Providers must bill the appropriate HCPCS codes for replacement parts for cochlear implants. Replacement parts **do not** require PA.

Do not bill HCPCS code A9900 for replacement parts for cochlear implants or MAA will deny the claim.

> ☞ **Note:** MAA does not reimburse providers for repairs or replacements that are covered under the manufacturer's warranty.

Urgent Care Site of Service Clarification

MAA incorrectly listed urgent care sites (place of service 20) under the facility setting (page J.2). Urgent care sites are considered to be non-facility centers as defined by Medicare policy. MAA has moved "urgent care facility" to the "Non-Facility Setting" grid on page J.3.

Multiple procedures performed on the same day

For multiple procedures performed on the same day (i.e., multiple lab or X-ray), providers must bill all procedures on the same claim form utilizing the appropriate modifiers if applicable.

Blepharoplasties

Blepharoplasties require PA, regardless of age.

Low Back Pain and Artificial Disc

MAA does note reimburse for Chartié artificial disc (total disc replacement procedure codes 0090T-0098T). These procedures are considered experimental.

Maximum Allowable Fee Correction

CPT code 57425 was inadvertently priced at the wrong conversion factor from July 1, 2004-June 30, 2005. **Effective for dates of service on and after July 1, 2005**, MAA has updated the fee with the correct conversion factor.

Procedure Code	Brief Description	July 1, 2005 Maximum Allowable Fee
57425	Laparoscopy, surg, colpopexy	$543.68

Reminders:

- MAA does not cover adult preventive exams.
- MAA limits preventive exams for clients with developmental disabilities to one per calendar year.
- To report critical care services provided in the outpatient setting for neonates and pediatric patients up through 24 months of age, bill using the appropriate CPT code (99291 or 99292).
- MAA does not cover services and/or devices that are considered experimental.
- MAA continues to follow Medicare's policy to not reimburse emergency room physicians for the following procedure codes: 90780, 90781, G0345, and G0356.
- MAA pays for one new patient visit per client, per provider or group practice.
- To report intensive (non-critical) low birth weight services, use the appropriate CPT code (99298 - 99299).
- MAA does not require PA on meningococal vaccines (CPT codes 90734 and 90733) or pneumococcal vaccines (CPT code 90732).

Billing Instructions Replacement Pages

Attached are replacement pages i-x, 1-2, A.1-A.4, B.1-B.4, B.7-B.16, C.5-C.6, C.9-C.20, D.1-D.16, E.5-E.22, F.7-F.8, F.15-F.42, G.3-G.10, H.1-H.2, I.1-I.22, J.1-J.2, K.3-K.10, L.1-L.6, M.1-M.6, and N.3-N.12 for MAA's current *Physician-Related Services Billing Instructions*.

How can I get MAA's provider issuances?

To obtain MAA's provider numbered memoranda and billing instructions, go to MAA's website at http://maa.dshs.wa.gov (click on the ***Billing Instructions/Numbered Memoranda*** or ***Provider Publications/Fee Schedules*** **link**).

To request a free paper copy from the Department of Printing:

1. **Go to: http://www.prt.wa.gov/** (Orders filled daily.)

   a) Click ***General Store***.

   b) If a **Security Alert** screen is displayed, click **OK.**

      i. Select either ***I'm New*** or ***Been Here***.
      ii. If new, fill out the registration and click ***Register***.
      iii. If returning, type your email and password and then click ***Login***.

   c) At the **Store Lobby** screen, click ***Shop by Agency***. Select ***Department of Social and Health Services*** and then select ***Medical Assistance.***

   d) Select ***Billing Instructions, Forms, Healthy Options, Numbered Memo, Publications,*** or ***Issuance Correction***. You will then need to select a year and the select the item by number and title.

2. **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX (360) 586-6361/ telephone (360) 586-6360. (Orders may take up to 2 weeks to fill.)

Introduction

Procedure Codes

The following types of procedure codes are used within these *Physician-Related Services Billing Instructions*:

- Current Procedure Terminology (CPT™); and
- Level II Healthcare Common Procedure Coding System (HCPCS).

Procedures performed must match the description and guidelines from the most current CPT or HCPCS manual for all MAA-covered services. **Due to copyright restrictions, MAA publishes only the official brief CPT descriptions. To view the full CPT description, please refer to your current CPT manual.**

☞ **Note:** MAA specifies in these billing instructions when MAA's guidelines differ from CPT. MAA adopts Medicare's guidelines and policies whenever possible.

Diagnosis Codes

MAA requires valid and complete ICD-9-CM diagnosis codes. When billing MAA, use the highest level of specificity (4^{th} or 5^{th} digits when applicable) or the services will be denied.

MAA does not cover the following diagnosis codes when billed as the primary diagnosis:

- E codes (Supplementary Classification);
- M codes (Morphology of Neoplasms); and
- Most V codes.

MAA reimburses providers for only those covered procedure codes and diagnosis codes that are within their scope of practice.

Grace Period for Discontinued Codes

MAA follows Medicare's policy eliminating the grace period for discontinued CPT and HCPCS procedure codes and ICD-9-CM diagnosis codes.

Noncovered Services [WAC 388-531-1900]

Procedures that are noncovered are noted with a pound (#) indicator in the Nonfacility Setting (NFS) and Facility Setting (FS) columns in the fee schedule.

If a client has extenuating medical circumstances that are not covered under the client's MAA program and the medical provider feels MAA should take these into consideration for coverage, the provider must submit a written request to MAA for an Exception to Rule (ETR). Send a completed "Fax/Written Request Basic Information" form [DSHS Form #13-756] to MAA (see Important Contacts section).

The following are examples of administrative costs and/or services not covered separately by MAA:

- Missed or canceled appointments;
- Adult preventive exams (except EPSDT exams for clients 20 years of age and younger and those clients with developmental disabilities);
- Mileage;
- Take-home drugs;
- Educational supplies or services;
- Copying expenses, reports, client charts, insurance forms;
- Service charges/delinquent payment fees;
- Telephoning for prescription refills;
- Other areas as specified in this fee schedule;
- After hours charges for services during regularly scheduled work hours.

Noncovered Practitioners [WAC 388-531-0250]

MAA does not reimburse for services performed by any of the following practitioners:

- Acupuncturists;
- Naturopaths;
- Homeopathists;
- Herbalists;
- Masseurs, masseuses;

- Christian Science practitioners or theological healers;
- Counselors (i.e., M.A. and M.S.N.);
- Sanipractors;
- Those who have a master's degree in social work (M.S.W.), except those employed by an FQHC or who have prior authorization to evaluate a client for bariatric surgery;
- Any other licensed or unlicensed practitioners not otherwise specifically provided for in WAC 388-502-0010;
- Any other licensed practitioners providing services that are not within the scope of the practitioner's license; and
- Any other licensed practitioners providing services that the practitioner is not trained to provide.

Clients Enrolled in MAA's Managed Care Plans

Many MAA clients are enrolled in one of MAA's managed care plans. These clients have an HMO identifier in the HMO column on their DSHS Medical ID card. They also receive an ID card from the managed care plan in which they are enrolled. Clients enrolled in one of MAA's managed care plans must obtain services through their managed care plan.

☞ **Note:** A client's enrollment can change monthly. Prior to serving a managed care client, make sure you receive approval from ***both*** the plan and the client's primary care provider (PCP), if required.

Send claims to the client's managed care plan for payment. Call the client's HMO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in WAC 388-502-0160.

By Report (BR)

Services with a **BR** indicator in the fee schedule (Section J) with billed charges of $1,100.00 or greater require a detailed report for payment purposes. Attach the report to the claim. **DO NOT** attach a report to the claim for services with a BR indicator with billed charges under $1,100.00 unless requested by MAA.

Acquisition Cost (AC)

Drugs with an **AC** indicator in the fee schedule (Section J) with billed charges of $1,100.00 or greater, or supplies with billed charges of $50.00 or greater, require a manufacturer's invoice for payment purposes. Attach the invoice to the claim, and indicate, if necessary, the quantity provided. **DO NOT** attach an invoice to the claim for procedure codes with an AC indicator for drugs with billed charges under $1,100.00, or supplies with billed charges under $50.00, unless requested by MAA.

☞ **Note:** Bill MAA for one unit of service only.

Conversion Factors

	7/1/00	7/1/01	7/1/02	7/1/03	7/1/04	7/1/05
Maternity	$45.33	$45.34	$45.59	$45.59	$44.46	$44.99
Anesthesia	$15.10	$15.49	$15.70	$20.23	$20.24	$20.44
Children's Primary Health Care	$35.89	$36.52	$35.62	$35.62	$34.25	$34.56
Adult Primary Health Care	$21.17	$21.27	$20.44	$25.00	$25.00	$24.82
All Other Procedure Codes	$22.37	$22.41	$22.75	$22.75	$22.67	$22.71
Clinical Lab Multiplication Factor	.694	.720	.719	.810	.797	.820

These conversion factors multiplied by the Relative Value Units (RVUs) establish the rates in this fee schedule.

National Correct Coding Initiative

MAA continues to evaluate and implement the National Correct Coding Initiative (NCCI) policy. This policy was created by the Centers for Medicare and Medicaid Services (CMS) to promote national correct coding methodologies. CCI assists MAA in controlling improper coding that may lead to inappropriate payment. MAA bases coding policies on the American Medical Association's Current Procedural Terminology (CPT) manual, national and local policies and edits, coding guidelines developed by national professional societies, the analysis and review of standard medical and surgical practices, and review of current coding practices. These correct coding policies do not necessarily supercede any other specific MAA coding, coverage, or payment policies, unless specifically stated. Visit the NCCI on the web at http://www.cms.hhs.gov/physicians/cciedits/default.asp? - comp.

Programs (Guidelines/Limitations)

Office and Other Outpatient Services

[Refer to WAC 388-531-0950]

In addition to the limitations on services indicated in the fee schedule, the following limitations apply:

MAA covers:

- One office or other outpatient visit per non-institutionalized client, per day for an individual provider (except for call-backs to the emergency room per WAC 388-531-0500).

  ✓ Certain procedures are included in the office call and cannot be billed separately.

  Example: MAA does not reimburse separately for ventilation management (CPT codes 94656, 94657, 94660, and 94662) when billed in addition to an Evaluation and Management (E&M) service, even if the E&M service is billed with modifier 25.

  ✓ Bill the appropriate level of E&M history and physical procedure **prior to performing dental surgery** in an outpatient setting. For clients assigned to an MAA managed care plan, bill MAA directly for history and physical claims for dental surgery with the appropriate ICD-9-CM dental diagnosis code. Indicate in the *Comments* section of the claim form that the service is a history and physical prior to dental surgery.

- Two physician visits per month for a client residing in a nursing facility or an intermediate care facility.

- One physical examination per client, per calendar year for clients with developmental disabilities as identified on the DSHS medical ID card. Use HCPCS procedure code T1023 with modifier HI and an ICD-9-CM diagnosis code from the range V79.3-V79.9 to bill for an annual exam
- MAA reimburses one new patient visit, per client, per provider or group practice.

Children's Primary Health Care (CPT codes 99201-99215)

- MAA pays a higher reimbursement rate for primary health care performed in the office setting (CPT codes 99201-99215) for children 20 years of age and younger. These are the only services that are reimbursed at the higher rate.

- If a child who is younger than one year of age **has not been issued** an individual Patient Identification Code (PIC), use the mother's or the father's PIC, and put a "B" in field 19 on the HCFA-1500 claims form. **In addition, you must add modifier HA to CPT codes 99201-99215 only** in order for the service to be reimbursed at the higher fee. If the mother is enrolled in an MAA managed care plan, newborns will be enrolled in the same managed care plan as their mother.

After Hours

MAA's policy for after hours is defined as:

- The physician is called to come back to the office after leaving for the day; or
- Services received after regular clinic/office hours.

For example: If a clinic closes at 5 pm and takes a break for dinner and then opens back up from 6 pm-10 pm, these services are not eligible for after hours service codes.

☞ **Note:** This policy does not include radiologists, pathologists, emergency room physicians or anesthesiologists. After hours CPT codes are not covered for any of these specialties.

Hospital Inpatient and Observation Care Services
(CPT codes 99217-99239) [Refer to WAC 388-531-0750]

MAA covers:

- One inpatient hospital call per client, per day for the same or related diagnoses. MAA does not reimburse separately for the hospital call if it is included in the global surgery reimbursement, MAA does not reimburse separately (See the Surgical Services Section; page F.16 for information on global surgery policy.)

- Professional inpatient services (CPT codes 99221-99223) during the global surgery follow-up period only if they are performed on an emergency basis and are unrelated to the original surgery. Use modifier 24 to indicate that the service is unrelated to the original surgery.

☞ **Note:** MAA reimburses providers for CPT codes 99221-99223 for scheduled hospital admissions during the follow-up period only when billed with a modifier 24.

- A hospital admission (CPT codes 99221-99223) billed by a psychiatrist in combination with one of the following:

  ✓ A psychiatric diagnostic or evaluative interview examination (CPT code 90801); or

  ✓ For children 20 years of age and younger, an interactive psychiatric diagnostic interview examination (CPT code 90802).

MAA does not cover:

- A hospital admission (CPT codes 99221-99223) and a planned surgery billed in combination. The hospital admission is included in the global fee for the surgery.

- Inpatient or observation care services [including admission and discharge services (CPT codes 99234-99236)] for stays of less than 8 hours on the same calendar date.

Other Guidelines:

- When a client is admitted for observation care for less than 8 hours and is discharged on the same calendar date, providers must bill using CPT codes 99218-99220. MAA does not reimburse providers separately for discharge services.

- When a client is admitted for observation care and is discharged on a different calendar date, providers must bill using CPT codes 99218-99220 **and** observation discharge CPT code 99217.

- When a client qualifies for an inpatient hospital admission and is discharged on a different calendar date, providers must bill using CPT codes 99221-99233 **and** hospital discharge day management CPT code 99238 or 99239.

- When a client qualifies for an inpatient hospital admission and is discharged on the same calendar date, providers must bill using CPT codes 99234-99236. MAA does not reimburse providers separately for hospital discharge day management services.

- Providers must satisfy the documentation requirements for both admission to and discharge from, inpatient or observation care in order to bill CPT codes 99234-99236. The length of time for observation care or treatment status must also be documented.

Detoxification Services

For clients receiving alcohol and/or drug detoxification services in an MAA-enrolled hospital-based detoxification center, providers must bill as follows:

Procedure Code-Modifier	Brief Description	Limitations
H0009	Alcohol and/or drug services [*bill for the initial admission*]	Limited to one per hospitalization. Restricted to ICD-9-CM diagnosis codes 292.0-292.9, 303.00-305.03, 305.20-305.93, and 790.3
H0009-TS	Alcohol and/or drug services with follow-up service modifier [*bill for any follow-up days*]	

☞ **Note**: Bill MAA directly for clients enrolled in an MAA managed care plan.

Emergency Physician-Related Services (CPT codes 99281-99285)

[Refer to WAC 388-531-0500]

- For services performed by the physician assigned to, or on call to, the emergency department, bill MAA using CPT codes 99281-99285.

☞ **Note**: For multiple emergency room (ER) visits on the same day with related diagnoses, the time(s) of the additional visit(s) must be noted in the *Comments* section of the claim form.

- MAA does not reimburse emergency room physicians for hospital admissions (e.g., CPT codes 99221-99223) or after-hours services (e.g., CPT codes 99050, 99052, or 99054).
- Physicians who perform emergency room services **must not** bill modifier 54 when billing MAA for surgical procedures.
- Physicians who provide only the follow-up services for minor procedures performed in emergency departments must bill the appropriate level of office visit code without modifier 55.
- **Effective for dates of service on and after July 1, 2005**, MAA will adopt Medicare's policy to not reimburse emergency room providers for the following procedure codes: CPT codes 90780 and 90781 and HCPCS codes G0345 and G0346.
- MAA does not reimburse emergency room providers for after hours CPT codes.

The following services (with their corresponding CPT codes) are included in critical care. Do not bill these separately:

- Vascular access procedures (36000, 36410, 36415 - 36416, 36540, and 36600);
- Gastric intubation (43752 and 91105);
- Chest x-rays (71010, 71015, and 71020);
- Temporary transcutaneous pacing (92953);
- The interpretation of cardiac output measurements (93561-93562);
- Ventilator management (94656-94657, and 94660-94662);
- Pulse oximetry (94760-94762); or
- Blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data) (99090).

Physician Standby Services (CPT code 99360)

[Refer to WAC 388-531-1250]

MAA covers physician standby services when those services are requested by another physician and involve prolonged physician attendance without direct (face-to-face) client contact.

☞ **Note:** The standby physician cannot provide care or services to other patients during the standby period.

Limitations

- Standby services of less than 30 minutes are not covered.
- After the first 30 minutes, subsequent periods of standby services are covered only when a full 30 minutes of standby is provided for each unit billed.

MAA does not cover physician standby services when:

- The provider performs a surgery that is subject to the "global surgery policy" (refer to page F.16);
- Billed in addition to any other procedure code, with the exception of CPT codes 99431 and 99440; or
- When the service results in an admission to a neonatal intensive care unit (CPT 99295) on the same day.

Prolonged Services (CPT codes 99354-99357)

[Refer to WAC 388-531-1350]

MAA covers prolonged services:

- Up to three hours per client, per diagnosis, per day.

> ☞ **Note:** The time counted toward payment for prolonged E&M services includes only direct face-to-face contact between the provider and the client, whether or not the services were continuous.

- Only when the provider performs one of the services listed below for the client on the same day:

Prolonged CPT Code	Other CPT Code(s)
99354	99201-99215, 99241-99245, 99301-99350
99355	99354 and one of the E&M codes required for 99354
99356	99221-99233, 99251-99255, 99261-99263
99357	99356 and one of the E&M codes required for 99356

> ☞ **Note:** Both the prolonged services CPT code ***and*** any of the "Other CPT Codes" listed above **must** be billed on the **same** claim.

Osteopathic Manipulative Therapy (CPT codes 98925-98929)

[Refer to WAC 388-531-1050]

MAA covers:

- Ten (10) osteopathic manipulations per client, per calendar year.
- Osteopathic Manipulative Therapy (OMT) services only when provided by an osteopathic physician licensed under chapter 18.71 RCW.
- OMT services by body regions. Body regions are defined as:

  - ✓ Head
  - ✓ thoracic
  - ✓ sacral
  - ✓ lower extremities
  - ✓ rib cage
  - ✓ cervical
  - ✓ lumbar
  - ✓ pelvic
  - ✓ upper extremities
  - ✓ abdomen and viscera

- One OMT procedure code in the range 98925-98929 per client, per day. Bill using the CPT code that describes the number of body regions involved. For example, if three body regions are manipulated, bill one unit of CPT code 98926.
- An E&M service (billed with modifier 25) in addition to the OMT, under one of the following circumstances:

  - ✓ When a provider diagnoses the condition requiring OMT and provides the therapy during the same visit;
  - ✓ When the existing condition fails to respond to OMT or significantly changes, requiring E&M services beyond those considered included in the manipulation codes; or
  - ✓ When the provider treats the client for a condition unrelated to the OMT during the same encounter.

  Justification for the E&M and OMT services must be documented and retained in the client's record for review.

☞ **Note:** MAA **does not cover** physical therapy services performed by osteopathic physicians.

Newborn Care

To assist providers in billing CPT codes with "newborn" in the description, MAA defines a newborn as younger than one year of age.

MAA covers:

- One newborn evaluation per newborn using either CPT code 99431 (hospital) or 99432 (birthing center or home births).
- Subsequent hospital care (other than initial evaluation or discharge) using CPT code 99433.
- Discharge services using either CPT code 99238 or 99239 for newborns admitted and discharged on different days.
- One newborn evaluation and discharge per newborn performed on the same day using CPT code 99435.

☞ **Note:** MAA covers circumcisions (CPT codes 54150 and 54160) ***only*** with medical ICD-9-CM diagnosis codes 605 (Phimosis), 607.1 (Balanoposthitis), or 607.81 (Balanitis Xerotica).

Neonatal Intensive Care Unit (NICU)/ Pediatric Intensive Care Unit (PICU) (CPT codes 99293-99299)

[Refer to WAC 388-531-0900]

NICU/PICU care includes management, monitoring, and treatment of the neonate/infant including respiratory, pharmacological control of the circulatory system, enteral and parenteral nutrition, metabolic and hematological maintenance, parent/family counseling, case management services, and personal direct supervision of the health care team's activities.

MAA covers:

- One NICU/PICU service per client, per day.
- NICU/PICU services when directing the care of a neonate/infant in a NICU/PICU. These codes represent care beginning with the date of admission to the NICU/PICU.

☞ **Note:** Once the infant is no longer considered critically ill, hospital care CPT codes 99231-99233 (>2500 grams) or 99298-99299 (<2500 grams) must be used.

- Newborn resuscitation (CPT code 99440) in addition to NICU/PICU services.

- The provider's attendance during the transport of critically ill or critically injured pediatric clients 24 months of age or younger to or from a facility or hospital (CPT code 99289 or 99290).

- Bill codes 99291-99292 for critical care services provided in an outpatient setting when the client is 24 months of age or younger

The following services and the subsequent intensive, noncritical services (with their corresponding CPT codes) are included in neonatal or pediatric critical care. Do not bill these separately:

- Bladder catheterization (51701, 51702);
- Central (36555) or peripheral vessel catheterization (36000);
- Continuous positive airway pressure (CPAP) (94660);
- Endotracheal intubation (31500);
- Initiation and management of mechanical ventilation (94656 and 94657);
- Invasive or noninvasive electronic monitoring of vital signs, bedside pulmonary function testing (94375), and/or monitoring or interpretation of blood gases or oxygen saturation (94760-94762);
- Lumbar puncture (62270);
- Oral or nasogastric tube placement (43752);
- Other arterial catheters (36140 and 36620);
- Umbilical arterial catheterization (36660);
- Umbilical venous catheterization (36510);
- Suprapubic bladder aspiration (51000);
- Surfactant administration, intravascular fluid administration (90780 and 90781);
- Transfusion of blood components (36430 and 36440); or
- Vascular punctures (36420 and 36600).

Intensive (Non-Critical) Low Birth Weight Services (99298-99299)

- Report only the appropriate procedure codes once per day, per client.
- These codes represent care beginning subsequent to the admission date.

Physician Care Plan Oversight (CPT codes 99375, 99378, and 99380)

[Refer to WAC 388-531-1150]

MAA covers:

- Physician care plan oversight services once per client, per month.
  - ✓ A plan of care must be established by the home health agency, hospice, or nursing facility.
  - ✓ The provider must perform 30 or more minutes of oversight services for the client each calendar month.

MAA does not cover:

- Physician care plan oversight services of less than 30 minutes per calendar month (CPT codes 99374, 99377, and 99379).
- Physician care plan oversight services provided by more than one provider during the global surgery reimbursement period, unless the care plan oversight is unrelated to the surgery.

Domiciliary, Rest Home, or Custodial Care Services

CPT codes 99301-99316 are ***not*** appropriate E&M codes for use in place of service 13 (Assisted Living) or 14 (Group Home). Providers must use CPT codes 99321-99333 for E&M services provided to clients in these settings.

Home Services

CPT codes 99341-99350 (Home Services) are only reimbursed in place of service 12 (home).

Telehealth

What is telehealth?

Telehealth is when a health care practitioner uses interactive real-time audio and video telecommunications to deliver covered services that are within his or her scope of practice to a client at a site other than the site where the provider is located.

Using telehealth when it is medically necessary enables the health care practitioner and the client to interact in real-time communication as if they were having a face-to-face session. Telehealth allows MAA clients, particularly those in medically underserved areas of the state, improved access to essential health care services that may not otherwise be available without traveling long distances.

The following services are ***not*** covered as telehealth:

- Email, telephone, and facsimile transmissions;
- Installation or maintenance of any telecommunication devices or systems;
- Home health monitoring; or
- "Store and forward" telecommunication based services. (Store and forward is the asynchronous transmission of medical information to be reviewed at a later time by the physician or practitioner at the distant site).

Who is eligible for telehealth?

Fee-for-service clients are eligible for medically necessary covered health care services delivered via telehealth. The referring provider is responsible for determining and documenting that telehealth is medically necessary. As a condition of payment, the client must be present and participating in the telehealth visit.

MAA will not pay separately for telehealth services for clients enrolled in a managed care plan. Clients enrolled in an MAA managed care plan will have a plan indicator in the HMO column on their DSHS Medical ID Card. Managed care enrollees must have all services arranged and provided by their primary care providers (PCP). Contact the managed care plan regarding whether or not the plan will authorize telehealth coverage. It is not mandatory that the plan reimburse for telehealth.

When does MAA cover telehealth?

MAA covers telehealth through the fee-for-service program when it is used to substitute for a face-to-face, "hands on" encounter for only those services specifically listed on page B.14.

Originating Site (Location of Client)

What is an "originating site"?

An originating site is the physical location of the eligible MAA client at the time the professional service is provided by a physician or practitioner through telehealth. Approved originating sites are:

- The office of a physician or practitioner;
- A hospital;
- A critical access hospital;
- A rural health clinic (RHC); and
- A federally qualified health center (FQHC).

Is the originating site reimbursed for telehealth?

Yes. The originating site is reimbursed a $20 facility fee per completed transmission.

How does the originating site bill MAA for the facility fee?

- *Hospital Outpatient*: When the originating site is a hospital outpatient department, payment for the originating site facility fee will be paid according to the maximum allowable fee schedule. To receive reimbursement for the facility fee, outpatient hospital providers must bill revenue code 0789 on the same line as HCPCS code Q3014.

- *Hospital Inpatient*: When the originating site is an inpatient hospital, there is no reimbursement to the originating site for the facility fee.

- *Critical Access Hospitals*: When the originating site is a critical access hospital outpatient department, payment is separate from the cost-based reimbursement methodology. To receive reimbursement for the $20.00 facility fee, critical access hospitals must bill revenue code 0789 on the same line as HCPCS code Q3014.

- *FQHCs and RHCs*: When the originating site is an FQHC or RHC, bill for the facility fee using HCPCS code Q3014. This is not considered an FQHC or RHC service and is not paid as an encounter, and is not reconciled in the monthly gross adjustment process.

- *Physicians' Offices*: When the originating site is a physician's office, bill for the facility fee using HCPCS code Q3014.

If a provider from the originating site performs a separately identifiable service for the client on the same day as telehealth, documentation for both services must be clearly and separately identified in the client's medical record.

Distant Site (Location of Consultant)

What is a "distant site"?

A distant site is the physical location of the physician or practitioner providing the professional service to an eligible MAA client through telehealth.

Who is eligible to be reimbursed for telehealth services at a distant site?

MAA reimburses the following provider types for telehealth services provided within their scope of practice to eligible MAA clients:

- Physicians (including Psychiatrists); and
- Advanced Registered Nurse Practitioners (ARNPs).

What services are covered using telehealth?

Only the following services are covered using telehealth:

- Consultations (CPT codes 99241-99275);
- Office or other outpatient visits (CPT 99201-99215);
- Psychiatric intake and assessment (CPT code 90801);
- Individual psychotherapy (CPT codes 90804-90809); and
- Pharmacologic management (CPT codes 90862).

> ☞ **Note**: Refer to other sections of these billing instructions for specific policies and limitation on these CPT codes.

How does the distant site bill MAA for the services delivered through telehealth?

The payment amount for the professional service provided through telehealth by the provider at the distant site is equal to the current fee schedule amount for the service provided.

Use the appropriate CPT codes **with modifier GT** (via interactive audio and video telecommunications system) when submitting claims to MAA for payment.

This page intentionally left blank.

☞ **Note:** A child placed outside of the home in the care of a relative does not qualify as a foster care client. However, MAA reimburses providers for an EPSDT screening exam without regard to the periodicity schedule for these clients using MAA's normal maximum allowable fee for EPSDT procedures. Providers must indicate "**EPSDT screen performed for child in relative care**" in the *Comments* section of the claim form.

To receive the enhanced rate, providers are required to use either:

- The DSHS "Well Child Examination" forms for Infancy, Early Childhood, Late Childhood, and Adolescence [DSHS 13-683 A-E(x), 13-684 A-C(x), 13-685 A-C(x), and 13-686A-B(x)] (see Important Contacts section for information on obtaining DSHS forms); **or**
- Another charting tool with equivalent information.

To obtain copies of the Well Child Examination forms:

- Submit a completed Forms and Publications Request form [DSHS # 17-011] to:

  Medical Assistance Administration
  PO Box 45530
  Olympia, WA 98504-5530
  FAX (360) 753-7315

-OR-

- Download an electronic copy of the Well Child Examination forms at: **http://www1.dshs.wa.gov/msa/forms/eforms.html**

What are the time limits for scheduling requests for EPSDT screenings?

Requests for EPSDT screenings must be scheduled within the following time limits:

If an EPSDT screening is requested through…	For clients who are…	Must be scheduled within…
MAA's Managed Care plans, Primary Care Case Management (PCCM), or Primary Care Providers (PCPs)	Infants - within the first 2 years of life.	21 days of request.
	Children – two years and older.	Six weeks of request.
	Receiving Foster Care – Upon placement	30 days of request, or sooner for children younger than 2 years of age.
Community Mental Health Center, Head Start, substance abuse provider, or Early Childhood Education and Assistance Program (ECEAP)	Birth through 20 years of age	14 days of the request.
Providers must ensure that when medically necessary services are identified during any EPSDT screening examination, appropriate treatment or referrals are made.		

EPSDT interperiodic screenings

☞ **Note:** MAA no longer reimburses providers for interperiodic screenings. If a client is seen for a suspected health problem, providers must bill these services using the appropriate level Evaluation & Management (E&M) procedure code, with the ICD-9-CM diagnosis code that accurately describes the sign(s), symptom(s), or condition(s) found. **It is no longer necessary to bill using modifier EP for these services**.

What if a medical problem is identified during an EPSDT screening?

If a medical problem is identified during a screening examination, the provider may:

- Refer the client to an appropriate MAA provider or MAA's Managed Care Plan provider, if applicable, for medical treatment; or
- Provide the service for the client (if it is within the provider's scope of practice).

☞ **Note:** If the provider is using the parent's PIC code to bill E&M codes 99201-99215 for an infant who has not yet been assigned a PIC code, the provider must use modifier HA in order to be reimbursed at the higher rate for EPSDT services. **Modifier HA must be the first modifier following the CPT or HCPCS code**. Any additional modifier may be listed second.

If the provider chooses to treat the medical condition on the same day as the screening exam, the provider must bill the appropriate level E&M code with modifier 25 in order to receive additional reimbursement for the office visit. Providers must bill using the appropriate ICD-9-CM medical diagnosis code that describes the condition found. **The E&M code and the EPSDT screening procedure code must be billed on separate claim forms.**

Referrals

Chiropractic Services

Eligible clients may receive chiropractic services when a medical need for the services is identified through an EPSDT screening. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary chiropractic services.

Dental Services

Eligible clients may go to a dental provider without an EPSDT screen or referral.

Clients age 18 years and younger – Vaccines that are identified by shading

- These vaccines are available at no cost from DOH. Therefore, MAA reimburses providers for an administration fee only.

- Bill for the administration of the vaccine by reporting the procedure code given with modifier SL (e.g., 90707 SL).

- DO NOT bill CPT codes 90471-90472 or 90465-90468 for the administration of the vaccine.

Clients age 18 years and younger – Vaccines not identified by shading

- Bill MAA for the cost of the vaccine itself by reporting the procedure code for the vaccine given. DO NOT use modifier SL with non-shaded vaccines. MAA reimburses providers for the vaccine using MAA's maximum allowable fee schedule.

- ***Do not*** bill any of the codes in the following table in combination with CPT codes 90471-90472. MAA limits reimbursement for immunization administration to a maximum of two vaccines (e.g., one unit of 90465 and one unit of 90466; or one unit of 90467 and one unit of 90468).

CPT Code	Brief Description
90465	Immune admin 1 inj, <8 yrs (may not be billed in conjunction with 90467
90466	Immune admin addl inj, < 8 yrs (must be reported in conjunction with 90465 or 90467)
90467	Immune admin O or N < 8 yrs (may not be reported in conjunction with 90465)
90468	Immune admin O/N, addl < 8 y (must be reported in conjunction with 90465 or 90467

☞ **Note:** MAA reimburses the above administration codes ***only*** when the physician counsels the client/family at the time of the administration and the vaccine **is not** available free of charge from the Health Department.

- Providers **must** bill the above administration codes on the **same** claim as the procedure code for the vaccine.

Clients age 19-20 years – All Vaccines

- Bill MAA for the cost of the vaccine itself by reporting the procedure code for the vaccine given. DO NOT use modifier SL with any of the vaccines for clients 19-20 years of age, regardless of whether the vaccine is shaded or not. MAA reimburses providers for the vaccine using MAA's maximum allowable fee schedule.

- Bill for the administration of the vaccine using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Reimbursement is limited to one unit of 90471 and one unit of 90472 (maximum of two vaccines).

- Providers **must** bill 90471 and 90472 on the **same** claim as the procedure code for the vaccine.

Clarification to Health Departments

Health Departments may bill CPT code 99211 when an immunization is the only service provided.

> **Example:** If a client receives an immunization that is not available free of charge from the Department of Health (DOH), you may bill CPT code 99211, the appropriate immunization administration code(s) (i.e. 90471-90472 or 90465-90468), and the vaccine. If the vaccine was received at no charge from DOH, you may bill 99211 and the appropriate vaccine code with modifier –SL.

Vaccines that are shaded in the table are available at no cost from DOH through the Universal Vaccine Distribution program and the Federal Vaccines for Children program for children age 18 years and younger.
MAA does not reimburse providers for these vaccines.

CPT	Vaccine	CPT	Vaccine
90585	Bcg vaccine, percut	90704	Mumps vaccine, sc
90586	Bcg vaccine, intravescial	90705	Measles vaccine, sc
90632	Hep a vaccine, adult im	90706	Rubella vaccine, sc
90633	Hep a vacc, ped/adol, 2 dose	90707	Mmr vaccine, sc
90636	Hep a/Hep B vacc (adult)	90708	Measles-rubella vaccine, sc
90645	Hib vaccine, hboc, im	90709	Rubella & mumpsvaccine, sc
90646	Hib vaccine, prp-d, im	90712	Oral poliovirus vaccine
90647	Hib vaccine, prp-omp, im	90713	Poliovirus, ipv, sc
90648	Hib vaccine, prp-t, im	90715	TdaP, 7 years and older, intramuscular
90655	Flu vacc split pres free 6-35 months	90716	Chicken pox vaccine, sc
90656	Flu vacc split pres free 3 years and above	90717	Yellow fever vaccine, sc
90657	Flu vaccine, 6-35 mo, im	90718	Td vaccine >7, im
90658	Flu vaccine, 3 yrs, im	90720	Dtp/hib vaccine, im
90660	Flu vacc, nasal (Covered October 1 through March 31 only)	90725	Cholera vaccine, injectable
90665	Lyme disease vaccine, im	90732	Pneumoccocal vacc, adult/ill
90669	Pneumococcal vacc, ped<5	90733	Meningococcal vaccine, sc
90675	Rabies vaccine, im	90734	Meningococcal vacc, intramuscular
90676	Rabies vaccine, id	90735	Encephalitis, vaccine, sc
90690	Typhoid vaccine, oral	90740	Hepb vacc, ill pat 3 dose im
90691	Typhoid vaccine, im	90743	Hep b vacc, adol, 2 dose, im
90692	Typhoid vaccine, h-p, sc/id	90744	Hep b vacc ped/adol 3 dose, im
90700	Dtap vaccine, im	90746	Hep b vaccine, adult, im
90701	Dtp vaccine, im	90747	Hep b vacc, ill pat 4 dose, im
90702	Dt vaccine <7, im	90748	Hep b/hib vaccine, im
90703	Tetanus vaccine, im	90749	Vaccine toxoid

***Due to its licensing agreement with the American Medical Association, MAA publishes only the official, brief CPT code descriptions. To view the full descriptions, please refer to your current CPT book*.**

Immunizations-Adults

(This section applies to clients 21 years of age and older. For clients 20 years of age and younger, refer to "Immunizations-Children")

- Bill MAA for the cost of the vaccine itself by reporting the procedure code for the vaccine given.
- MAA reimburses providers for the vaccine using MAA's maximum allowable fee schedule.
- Bill for the administration of the vaccine using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Reimbursement is limited to one unit of 90471 and one unit of 90472 (maximum of two vaccines).
- Providers **must** bill 90471 and 90472 on the **same** claim as the procedure code for the vaccine.

CPT	Immunization	CPT	Immunization
90585	Bcg vaccine, precut	90707	Mmr vaccine, sc
90586	Bcg vaccine, intravesical	90708	Measles-rubella vaccine, sc
90632	Hep a vaccine, adult im	90709	Rubella & mumps vaccine, sc
90636	Hep a/hep b vacc, adult im	90712	Oral poliovirus vaccine
90645	Hib vaccine, hboc, im	90713	Poliovirus, ipv, sc
90646	Hib vaccine, prp-d, im	90715	TdaP, 7 years and older, Intramuscular
90647	Hib vaccine, prp-omp, im		
90648	Hib vaccine, prp-t, im	90716	Chicken pox vaccine, sc
90656	Flu vacc split pres free 3 years and above	90717	Yellow fever vaccine, sc
		90718	Td vaccine >7, im
90658	Flu vaccine, 3 yrs, im	90720	Dtp/hib vaccine, im
90660	Flu vacc, nasal (Covered October 1 through March 31 only)	90725	Cholera vaccine, injectable
		90732	Pneumococcal vacc, adult/ill
90665	Lyme disease vaccine, im	90733	Meningococcal vaccine, sc
90675	Rabies vaccine, im	90734	Meningococcal vacc, intramuscular
90676	Rabies vaccine, id	90735	Encephalitis vaccine, sc
90690	Typhoid vaccine, oral	90740	Hepb vacc, ill pat 3 dose, im
90691	Typhoid vaccine, im	90746	Hep b vaccine, adult, im
90692	Typhoid vaccine, h-p, sc/id	90747	Hepb vacc, ill pat 4 dose, im
90701	Dtp vaccine, im	90748	Hep b/hib vaccine, im
90703	Teanus vaccine, im	90749	Vaccine toxoid
90704	Mumps vaccine, sc		
90706	Rubella vaccine, sc		

Immune Globulins

☞ **Note:** MAA does not reimburse immune globulins that are obtained free of charge.

- **RespiGam** – Do not bill CPT code 90379 for RespiGam. You must use HCPCS code J1565.

- **Synagis** (CPT code 90378)

  ✓ Bill one unit for each 50 mg of Synagis used.

  ✓ MAA covers Synagis for those clients 11 months of age and younger from December 1 - April 30 of any given year without prior authorization (PA).

  ✓ PA is required for all other time periods and for all other age groups.

  Requests for authorization must be submitted in writing to:

  MAA-Division of Medical Management
  Attn: Synagis Program
  PO Box 45506
  Olympia, WA 98504-5506
  FAX: (360) 725-2141

- **Hepatitis B** (CPT code 90371) - Reimbursement is based on the number of 1.0 ml syringes used. Bill each 1.0 ml syringe used as 1 unit.

- **Varicella Zoster** (CPT code 90396) - Each one unit billed equals one 125-unit vial, with a maximum reimbursement of five vials per session.

- **Rabies Immune Globulin (RIG) (CPT codes 90375-90376)**

  ✓ RIG is given based on .06 ml per pound of body weight. The dose is rounded to the nearest tenth of a milliliter (ml). Below are the recommended dosages up to 300 pounds of body weight:

Pounds	Dose
0-17	1 ml
18-34	2 ml
35-50	3 ml
51-67	4 ml
68-84	5 ml
85-100	6 ml
101-117	7 ml
118-134	8 ml
135-150	9 ml

Pounds	Dose
151-167	10 ml
168-184	11 ml
185-200	12 ml
201-217	13 ml
218-234	14 ml
235-250	15 ml
251-267	16 ml
268-284	17 ml
285-300	18 ml

  ✓ RIG is sold in either 2 ml or 10 ml vials.
  ✓ One dose is allowed per episode.
  ✓ Bill one unit for each 2 ml vial used per episode.

  Examples:

  ✓ If a client weighs 83 pounds, three 2 ml vials would be used. The number of units billed would be three; or
  ✓ If a client weighs 240 pounds, both one 10 ml vial and three 2 ml vials or eight 2 ml vials could be used. The number of units billed would be eight.

- **Correct Coding for Various Immune Globulins –** Bill MAA for immune globulins using the HCPCS procedure codes listed below. MAA does not reimburse for the CPT codes listed in the Noncovered CPT Code column below.

Noncovered CPT Code	Covered HCPCS Code
90281	J1460-J1560
90283	J1563
90291	J0850
90379	J1565
90384	J2790
90385	J2790
90386	J2792
90389	J1670

Therapeutic or Diagnostic Injections

(CPT codes 90780-90788, 90799, and HCPCS codes G0345 – G0353)
[Refer to WAC 388-531-0950]

- MAA reimburses providers for injection procedures and/or injectable drug products provided to a client only when the injectable drug used is from office stock purchased by the provider from a pharmacist or drug manufacturer. Providers must not bill MAA for drugs obtained free of charge (e.g. free samples).

- If no other service is performed on the same day, a subcutaneous or intramuscular injection (CPT code 90782 or HCPCS code G0351) or an intramuscular antibiotic injection (CPT code 90788) can be billed in addition to an injectable drug code.

- When a subcutaneous or intramuscular injection (CPT code 90782 or HCPCS code G0351) or an intramuscular antibiotic injection (CPT code 90788) is provided on the same day as an Evaluation & Management (E&M) service, the injections are bundled into the E&M service and are not reimbursed separately.

- Intra-arterial injections (CPT code 90783) and intravenous therapeutic or diagnostic injections (CPT code 90784 or HCPCS code G0353) are reimbursed separately even when provided on the same day as an E&M service. Separate payment for the drug is allowed using the appropriate HCPCS injection drug code. However, these injections are not reimbursed separately if provided in conjunction with IV infusion therapy services (CPT codes 90780 and 90781 or HCPCS codes G0345 – G0349).

- Do not bill CPT codes 90780 – 90788 in combination with HCPCS codes G0345 – G0353. MAA does not reimburse providers for CPT code 99211 on the same date of service as drug administration HCPCS codes G0345 – G0349, G0351 – G0353, and CPT codes 90780 – 90788. If billed in combination, MAA will deny the E&M code 99211. However, providers may bill other E&M codes on the same date of service using modifier 25 to indicate that a significant and separately identifiable services was provided. If modifier 25 is not utilized, MAA will deny the drug administration code.

Note: Drugs must be billed using the HCPCS drug codes and are reimbursed at MAA's established maximum allowable fees. Name, strength, and dosage of the drug must be documented and retained in the client's file for review. For billing information and reimbursement of chemotherapy services, see page F.15.

Hyalgan/Synvisc

- MAA reimburses only orthopedic surgeons and rheumatologists for Hyalgan or Synvisc.
- MAA allows a maximum of 5 Hyalgan or 3 Synvisc intra-articular injections **per knee** for the treatment of pain in osteoarthritis of the knee. Identify the left knee or the right knee by adding the modifier LT or RT to your claim.
- This series of injections may be repeated at 12-week intervals.
- Providers must bill for Hyalgan and Synvisc using the following HCPCS codes:

HCPCS Code	Description	Limitations
J7317	Sodium hyaluronate, 20-25 mg, for intra-articular injection (Hyalgan)	Maximum of 5 injections Maximum of 5 units (1 unit = 1 injection of 20-25 mg)
J7320	Hylan G-F 20, 16 mg, for intra-articular injection (Synvisc)	Maximum of 3 injections Maximum of 3 units (1 unit = 1 injection of 16 mg)

- Hyalgan and Synvisc injections are covered for treatment of osteoarthritis of the knee only with the following ICD-9-CM diagnosis codes:

Diagnosis Code	Description
715.16	Osteoarthritis, localized, primary lower leg.
715.18	Osteoarthritis, localized, primary, other specified sites.
715.26	Osteoarthritis, localized, secondary, lower leg.
715.28	Osteoarthritis, localized, secondary, other specified sites
715.36	Osteoarthritis, localized, not specified whether primary or secondary, lower leg.
715.38	Osteoarthritis, localized, not specified whether primary or secondary, other specified sites.
715.96	Osteoarthritis, unspecified whether generalized or localized, lower leg.
715.98	Osteoarthritis, unspecified whether generalized or localized, other specified sites.

- The injectable drugs must be billed after all injections are completed. The drugs are billed as a maximum of 5 units for Hyalgan or a maximum of 3 units for Synvisc (per knee).
- Bill CPT injection code 20610 each time an injection is given, up to a maximum of 5 injections for Hyalgan or 3 injections for Synvisc.
- You must bill both the injection CPT code and HCPCS drug code on the same claim form.

Clarification of Coverage Policy for Certain Injectable Drugs

In certain circumstances, MAA limits coverage for some procedures and/or injectable drugs given in a physician's office to specific diagnoses or provider types only. This policy is outlined in previous memoranda. Although these memoranda were superseded, the policy regarding limited coverage for some procedures and/or injectable drugs remains in effect.

Limitations on coverage for certain injectable drugs are listed below:

Procedure Code	Brief Description	Limitation Restricted to ICD-9-CM
J0637	Caspofungin acetate	117.3 (aspergillosis)
J0725	Chorionic gonadotropin/1000u	752.51 (Undescended testis)
J1055	Medroxyprogester acetate inj (depo provera)	Females-only diagnoses V25.02 or V25.3 or V25.49 or V25.9. (contraceptive mgmt) Males-diagnosis must be related to cancer
J1212	Dimethyl sulfoxide 50% 50 ML	595.1 (chronic intestinal cystitis)
J1595	Injection glatiramer acetate	340 (multiple sclerosis)
J1756	Iron sucrose injection	585(chronic renal failure)
J2324	Nesiritide	No diagnosis restriction. Restricted use only to cardiologists
J2501	Paricalcitol	585 (chronic renal failure)
J2916	Na ferric gluconate complex	585 (chronic renal failure)
J3420	Vitamin b12 injection	123.4, 151.0-154.8, 157.0-157.9, 197.4-197.5, 266.2, 281.0-281.3, 281.9, 284.0, 284.8-284.9, 555.9, 579.0-579.9, 648.20-648.24
J3465	Injection, voriconazole	117.3 (aspergillosis)
J3487	Zoledronic acid	198.5, 203.00-203.01, and 275.42 (hypercalcemia)
J9041	Bortezomib injection	203.00-203.01 (multiple myeloma and immunoproliferative neoplasms)
Q3025	IM inj interferon beta 1-a	340 (multiple sclerosis)
Q3026	Suc inj interferon beta 1-a	340 (multiple sclerosis)
Q4077	Treprostinil, 1 mg	416.0-416.9 (chronic pulmonary heart disease)

Clarification of Coverage Policy for Miscellaneous Procedures

- Limitations on coverage for certain miscellaneous procedures are listed below:

Procedure Code	Brief Description	Limitation Restricted to ICD-9-CM
11980	Implant hormone pellet(s)	257.2 and 174.0-174.9
S0139	Minoxidil, 10 mg	401.0-401.9 (essential hypertension)
S0189	Testosterone pellet 75 mg	257.2, 174.0-174.9 and only when used with CPT code 11980

Verteporfin Injection (HCPCS code J3396)

Verteporfin injections are limited to ICD-9-CM diagnosis code 362.52 (exudative senile macular degeneration).

Clozaril Case Coordination

- Providers must bill for Clozaril case coordination using CPT code 90862 (pharmacologic management).
- MAA reimburses only physicians, psychiatrists, ARNPs, and pharmacists for Clozaril case coordination.
- MAA reimburses providers for one unit of Clozaril case coordination per week.
- MAA reimburses providers for Clozaril case coordination when billed with ICD-9-CM diagnosis codes 295.00 – 295.9 only.
- Routine venipuncture (CPT code 36415) and a blood count (CBC) may be billed in combination when providing Clozaril case coordination.

Botulism Injections **(HCPCS code J0585 and J0587)**

MAA requires PA for HCPCS codes J0585 and J0587 **regardless of the diagnosis**.

MAA approves Botulism injections with prior authorization:

- For the treatment of:
  - ✓ Cervical dystonia;
  - ✓ Blepharospasm; and
  - ✓ Lower limb spasticity associated with cerebral palsy in children; and
- As an alternative to surgery in patients with infantile esotropia or concomitant strabismus when:
  - ✓ Interference with normal visual system development is likely to occur; and
  - ✓ Spontaneous recovery is unlikely.

This page intentionally left blank.

Vision Care Services (Includes Ophthalmological Services)

Who is eligible for vision care? [WAC 388-544-0100 (1)]

Clients with one of the following medical program identifiers on their DSHS Medical Identification cards are eligible for vision care:

Medical Program Identifier	Medical Program Description
CNP	Categorically Needy Program
CNP – CHIP	Categorically Needy Program – State Children's Health Insurance Program
LCP – MNP	Limited Casualty Program – Medically Needy Program
GA-U **No Out of State Care**	General Assistance-Unemployable – No Out of State Care (except in designated bordering cities)
General Assistance	ADATSA

Limited Coverage:

- MAA covers vision care under Emergency Medical Only program (may also be referred to as the alien emergency medical (AEM) program) **only** when the services are directly related to an emergency medical condition, and prior authorization is obtained.

- For Qualified Medicare Beneficiary clients, MAA pays only for Medicare premium co-pays, coinsurance, and deductibles.

No Coverage:

Clients with Family Planning Only and TAKE CHARGE medical program identifiers do **not** have vision care coverage.

MAA Managed Care Clients [Refer to WAC 388-544-0100 (2)]

Clients with an identifier in the HMO column on their DSHS Medical ID cards are enrolled in one of MAA's managed care plans and are covered for vision care services as follows:

- **Eye exams, refractions, and/or visual fields** must be requested and provided directly through the client's managed care plan. Clients can contact their plans by calling the telephone number listed on their Medical ID card;

- **Eyeglass frames, lenses, and contact lenses** must be ordered from MAA's contractor. These items are covered fee-for-service. (See Section E – *Where and How do I Order*?) Use the guidelines found in this billing instruction for clients enrolled in an MAA managed care plan.

Primary Care Case Management (PCCM) clients will have the PCCM identifier in the HMO column on their Medical ID cards. Please make sure these clients have been referred by their PCCM prior to receiving services. The referral number is required in field **17a** on the HCFA-1500 claim form. (See Section G - *General Billing* for further information.)

> ☞ **Note:** For further information on MAA's managed care plans, see MAA's website: http://maa.dshs.wa.gov/HealthyOptions

Coverage – Examinations and Refractions

When does MAA cover eye examinations and refraction services?
[Refer to WAC 388-544-0250 (1)]

MAA covers eye examinations and refraction services for asymptomatic clients as follows:

- For **adults** (clients 21 years of age or older): Once every 24 months;

- For **children** (clients 20 years of age or younger): Once every 12 months;

- For **clients with developmental disabilities** (regardless of age): Once every 12 months.

The provider must document the diagnosis and/or treatment in the client's record to justify the frequency of examinations and other services.

Exams/Refractions Due to Medical Conditions or Medication

[Refer to WAC 388-544-0250 (2)]

MAA covers medically necessary nursing facility visits (procedure codes 99311 – 99313). There must be communication between the attending physician and the consulting specialist regarding the resident's specific needs. Group vision screenings are not covered (see page D.16 *Noncovered Services*).

MAA covers eye examinations and refraction services as often as medically necessary when:

- The provider is diagnosing or treating the client for a medical condition that has symptoms of vision problems or disease (e.g., glaucoma, conjunctivitis, corneal abrasion/laceration, etc.); or

- The client is on medication that affects vision.

Exams/Refractions Due to Lost or Broken Hardware

[Refer to WAC 388-544-0250 (3)]

MAA covers eye examinations/refractions outside the time limitations listed on page D.2 when the eye examination/refraction is necessary due to lost or broken eyeglasses/contacts. To receive payment:

- For **adults** (clients 21 years of age or older),), providers must follow the expedited prior authorization (EPA) process (see Section I – *Authorization* **EPA# 610**) and document the following in the client's file:

  - ✓ The eyeglasses or contacts are lost or broken; and
  - ✓ The last examination was at least 18 months ago;

- For **children** (clients 20 years of age or younger), MAA does **not** require prior authorization;

- For **clients with developmental disabilities** (regardless of age), MAA does **not** require prior authorization.

Visual Field Exams [Refer to WAC 388-544-0250 (4)]

MAA covers visual field exams (e.g., CPT codes 92081, 92082, and 92083) for the diagnosis and treatment of abnormal signs, symptoms, or injuries.

> **Note:** MAA does not reimburse for visual field exams that are done by simple confrontation. Use Medicare criteria for the billing of visual field services for MAA clients. Your records must support the medical necessity for the visual field tests.

To receive payment, providers must document all of the following in the client's record:

- The extent of the testing;
- Why the testing was reasonable and necessary for the client; and
- The medical basis for the frequency of testing.

Coverage – Eyeglasses (Frames and/or Lenses) and Repair Services

When does MAA cover eyeglasses (frames and/or lenses)?
[Refer to WAC 388-544-0300 (1)]

MAA covers eyeglasses for asymptomatic clients as follows:

- For **adults** (clients 21 years of age or older): Once every 24 months;
- For **children** (clients 20 years of age or younger): Once every 12 months;
- For **clients with developmental disabilities** (regardless of age): Once every 12 months.

Clinical Criteria for Asymptomatic Clients

MAA covers eyeglasses for asymptomatic clients when the client meets the following clinical criteria:

- The client has a stable visual condition (see Definitions section – *stable visual condition*);
- The client's treatment is stabilized;
- The client's prescription is less than 18 months old; and
- One of the following minimum correction needs **in at least one eye** is documented in the client's file:
  - ✓ Sphere power equal to, or greater than, plus or minus 0.50 diopter;
  - ✓ Astigmatism power equal to, or greater than, plus or minus 0.50 diopter; or
  - ✓ The add power equal to or greater than 1.0 diopter for bifocals or trifocals.

☞ **Note:** MAA limits eyeglass reimbursement to specific frames, lenses, and contact lenses as offered by the MAA contractor. MAA pays a fitting fee **only** for frames, lenses, and contact lenses provided by or obtained through MAA's contractor (see Section E: *Where and How Do I Order?*).

Accommodative Esotropia or Strabismus [WAC 388-544-0300 (2)]

MAA covers eyeglasses and/or lenses for clients who are 20 years of age or younger with a diagnosis of accommodative esotropia or any strabismus correction. In this situation, the client is not subject to the clinical criteria on page I.15.

Durable or Flexible Frames [WAC 388-544-0300 (3)]

MAA covers selected frames called "durable" or "flexible" frames through MAA's contracted supplier when the client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a 12-month period. Providers must follow the expedited prior authorization process (see Section I – *Authorization* **EPA# 619, EPA# 620**).

Nonallergenic Frames [WAC 388-544-0300 (4)]

MAA covers the cost of coating contract eyeglass frames to make the frames nonallergenic if the client has a medically diagnosed and documented allergy to the materials in the available eyeglass frames.

Incidental Repairs [WAC 388-544-0300 (5)]

MAA pays for incidental repairs to a client's eyeglass frames when **all** of the following apply:

- The provider typically charges the general public for the repair or adjustment;
- The contractor's one year warranty period has expired; **and**
- The cost of the repair does not exceed MAA's cost for replacement frames.

Note: Incidental repairs are billable by ophthalmologists, optometrists, and opticians.

Eyeglass repair parts and materials may be ordered from the state contractor or any manufacturer of optical devices and will be paid up to MAA's maximum allowable fee for repair.

Use the following procedure code when billing MAA for an eyeglass repair. Include an invoice when you bill:

CPT Procedure Code	Description
92390	Materials for eyeglass repair (specify materials billed).

Note: Use CPT code 92390 for repairs only when materials are being replaced. Materials must be documented with an invoice or statement from the manufacturer or the contractor showing the client's name and date. If the needed materials are in stock and a charge is normally made to the public for these materials, the repair fee requirement would be satisfied providing that the use of the specific part is documented in the client's record.

Replacement Frames and/or Lenses [Refer to WAC 388-544-0300 (6)]

MAA covers replacement eyeglass frames and/or lenses that have been lost or broken. To receive payment:

- For **adults** (clients 21 years of age or older) providers must follow the expedited prior authorization process (see Section I – *Authorization* **EPA# 615, EPA# 618**);

- For **children** (clients 20 years of age or younger) MAA does **not** require prior authorization;

- For **clients with developmental disabilities** (regardless of age) MAA does **not** require prior authorization.

Back-up Eyeglasses [Refer to WAC 388-544-0300 (7)]

MAA covers one pair of back-up eyeglasses when contact lenses are medically necessary and the contact lenses are the client's primary visual correction aid (see Contact Lenses, page C.11). MAA limits back-up eyeglasses as follows:

- For **adults** (clients 21 years or older): Once every 6 years.
- For **children** (clients 20 years or younger): Once every 2 years.
- For **clients with developmental disabilities** (regardless of age): Once every 2 years.

Coverage – Plastic Eyeglass Lenses and Services

When does MAA cover eyeglass lenses and services?
[Refer to WAC 388-544-0350 (1)]

MAA covers the following plastic scratch-resistant eyeglass lenses:

- Single vision lenses;
- Round or flat top D-style bifocals;
- Flat top trifocals; and
- Slab-off and prism lenses (including Fresnel lenses).

> **Note:** MAA's contractor supplies **all** plastic eyeglass lenses with a scratch-resistant coating.

Replacing Bifocal or Trifocal Eyeglass Lenses
[Refer to WAC 388-544-0350 (2)]

MAA allows bifocal eyeglass lenses to be replaced with trifocal or single vision lenses, or trifocal lenses to be replaced with bifocals or single vision lenses when all of the following apply:

- A client has attempted to adjust to the bifocals or trifocals for at least 60 days;
- The client is unable to make the adjustment; and
- The bifocal or trifocal lenses being replaced are returned to the provider.

High Index Eyeglass Lenses [Refer to WAC 388-544-0350 (3)]

MAA covers high index lenses for clients who require one of the following in at least one eye:

- A spherical refractive correction of plus or minus 8.0 diopters or greater; or
- A cylinder correction of plus or minus 3.0 diopters or greater.

To receive payment, providers must follow the expedited prior authorization process (see Section I- *Authorization* **EPA# 625**).

Tinting [Refer to WAC 388-544-0350 (4)]

MAA covers the tinting of plastic lenses through MAA's contracted lens supplier when the client's medical need is diagnosed and documented as one or more of the following chronic (expected to last longer than 3 months) eye conditions causing photophobia:

Medical Problems	ICD-9-CM Diagnosis Codes
Blindness	369.00 - 369.9
Chronic corneal keratitis	370.00 - 370.07
Chronic iritis, iridocyclitis (uveitis)	364.10 - 364.11 364.51 - 364.59
Diabetic retinopathy	362.01 - 362.02
Fixed pupil	379.42 - 379.49
Glare from cataracts	366.00 - 366.9
Macular degeneration	362.50 - 362.66
Migraine disorder	346.00 - 346.91
Ocular albinism	270.2
Optic atrophy and/or optic neuritis	377.10 - 377.63
Rare photo-induced epilepsy conditions	345.00 - 345.91
Retinitis pigmentosa	362.74

Photochromatic Eyeglass Lenses [Refer to WAC 388-544-0350 (5)]

MAA covers both *tinted* lenses and *photochromatic* lenses for appropriate medical conditions. *Tinted* lenses are colored lenses that remain the same color indoors and outdoors. *Photochromatic* lenses are lenses that darken when they are exposed to sunlight (photochromatic lenses do not darken as well inside automobiles).

MAA covers photochromatic lenses when the client's medical need is diagnosed and documented as related to either of the following:

Medical Problems	ICD-9-CM Diagnosis Codes
Ocular Albinism	270.2
Retinitis pigmentosa	362.74

Polycarbonate Eyeglass Lenses [Refer to WAC 388-544-0350 (6)]

MAA covers polycarbonate lenses for clients with developmental disabilities.

MAA covers polycarbonate lenses for clients without developmental disabilities as follows:

Medical Problems	ICD-9-CM Diagnosis Codes
For clients who are blind in one eye and need protection for the other eye, regardless of whether a vision correction is required	369.60 - 369.69 369.70 - 369.76
For infants and toddlers with motor ataxia	331.89, 781.2 334.0 - 334.9, 781.3
For clients 20 years of age or younger who are diagnosed with strabismus	378.00 - 378.9
For clients 20 years of age or younger who are diagnosed with amblyopia	368.01 - 368.03

Requests for Eyeglass Lenses Only [Refer to WAC 388-544-0350 (7)]

MAA covers requests for lenses only (lenses without frames) for clients who own their own eyeglass frames not purchased by MAA when:

- The eyeglass frames are serviceable; and
- The size and style of the required lenses meet MAA's contract requirements. The lenses must be compatible with MAA's contracted frames.

> ☞ **Note:** Due to time, exposure to elements, and concealed damage, working with a client's frames can be unpredictable. MAA and MAA's contractor **do not** accept responsibility for these frames.

Replacements due to Lost or Broken Eyeglass Lenses

[Refer to WAC 388-544-0350 (8)(a)]

MAA covers replacement eyeglass lenses that have been lost or broken. To receive payment:

- For **adults** (clients 21 years of age or older) providers must follow the expedited prior authorization process (see Section I – *Authorization* **EPA# 623**);
- For **children** (clients 20 years of age or younger) MAA does not require prior authorization;
- For **clients with developmental disabilities** (regardless of age) MAA does not require prior authorization.

Replacements due to Refractive Changes

[WAC 388-544-0350 (8)(b) and (c)]

MAA covers eyeglass lens replacements due to refractive changes, without regard to time limits, when caused by one of the following:

- **Eye surgery**, the **effect(s) of prescribed medication**, or **one or more diseases affecting vision.** For each of these, all of the following must be documented in the client's file:

  - ✓ The client has a stable visual condition (see Definitions section for a definition of *stable visual condition*);
  - ✓ The client's treatment is stabilized;
  - ✓ The lens correction must have a 1.0 or greater diopter change between the sphere or cylinder correction in at least one eye; **and**
  - ✓ The previous and new refraction.

  To receive payment, providers must follow the expedited prior authorization process (see Section I – *Authorization* **EPA# 622**).

- **Headaches**, **blurred vision**, or **difficulty with school or work**. For each of these, all of the following must be documented in the client's file:

  - ✓ Copy of the current prescription (the prescription is less than 18 months old);
  - ✓ Date of last dispensing, if known;
  - ✓ Absence of a medical condition that is known to cause temporary visual acuity changes (e.g., diabetes, pregnancy, etc.); **and**
  - ✓ A refractive change of at least .75 diopter or greater between the sphere or cylinder correction in at least one eye.

  To receive payment, providers must follow the expedited prior authorization process (see Section I- *Authorization* **EPA# 624**).

Coverage – Contact Lenses and Services

What types of contact lenses and services does MAA cover?

[Refer to WAC 388-544-0400 (1) through (3)]

MAA covers the following types of contact lenses as the client's primary refractive correction method when a client has a spherical correction of plus or minus 6.0 diopters or greater in at least one eye. In order to qualify for the spherical correction, the prescription may be from either the glasses or the contact lenses prescriptions and/or written in either "minus cyl" or "plus cyl" form. (See below for exceptions to the plus or minus 6.0 diopter criteria):

1. **Conventional soft** or **rigid gas permeable** contact lenses that are prescribed for daily wear;

2. **Disposable** contact lenses that are prescribed for daily wear and have a monthly or quarterly planned replacement schedule, as follows:

- 12 pairs of monthly replacement contact lenses; or
- 4 pairs of 3-month replacement contact lenses.

Medical Problems	ICD-9-CM Diagnosis Code
Hypermetropia	367.0
Myopia	367.1

Exception:

For clients diagnosed with **high anisometropia**, MAA covers the contact lenses above when the client's refractive error difference between the two eyes is plus or minus 3.0 diopters and eyeglasses cannot reasonably correct the refractive errors.

Medical Problems	ICD-9-CM Diagnosis Code
High anisometropia	367.31

A client who qualifies for contact lenses as the primary refractive correction method must choose one style of contact lenses from those listed in #1 or #2 above for each 12-month period of coverage.

Soft Toric Contact Lenses [Refer to WAC 388-544-0400 (4)]

MAA covers soft toric contact lenses for clients with astigmatism requiring a cylinder correction of plus or minus 1.0 diopter in at least one eye. The client must have a spherical correction of plus or minus 6.0 diopters or greater in at least one eye.

Medical Problems	ICD-9-CM Diagnosis Code
Astigmatism	367.20 - 367.22

Specialty Contact Lens Designs [Refer to WAC 388-544-0400 (5)]

MAA covers specialty contact lens designs for clients who are diagnosed with one or more of the following:

Medical Problems	ICD-9-CM Diagnosis Code
Aphakia	379.31 743.35
Keratoconus	371.60-371.62 743.41
Corneal softening	371.23

Replacement Contact Lenses – Lost or Damaged

[Refer to WAC 388-544-0400 (6)(a) and (c)]

MAA covers replacement contact lenses once every 12 months for lost or damaged contact lenses. To receive payment:

- For **adults** (clients 21 years of age or older): Providers must follow the expedited prior authorization process (see Section I – *Authorization* **EPA# 627**);
- For **children** (clients 20 years of age or younger): MAA does not require prior authorization;
- For **clients with developmental disabilities** (regardless of age): MAA does not require prior authorization.

Replacement Contact Lenses – Surgery/Medication/Disease

[Refer to WAC 388-544-0400 (6)(b) and (c)]

MAA covers replacement contact lenses as often as medically necessary when all of the following apply:

- One of the following cause the vision change:
  - ✓ Eye surgery;
  - ✓ The effect(s) of prescribed medication; or
  - ✓ One or more diseases affecting vision; **and**
- The client has a stable visual condition (see Definitions section – *stable visual condition*); **and**
- The client's treatment is stabilized; **and**
- The lens correction has a 1.0 or greater diopter change in at least one eye between the sphere or cylinder correction. The previous and new refraction must be documented in the client's record.

To receive payment for replacement contacts related to surgery, medication, or disease:

- For **adults** (clients 21 years of age or older): Providers must follow the expedited prior authorization process (see Section I – *Authorization* **EPA# 621**);
- For **children** (clients 20 years of age or younger): MAA does not require prior authorization;
- For **clients with developmental disabilities** (regardless of age): MAA does not require prior authorization.

Therapeutic Contact Bandage Lenses [Refer to WAC 388-544-0400 (7)]

MAA covers therapeutic contact bandage lenses only when needed immediately after either of the following:

Medical Problems	ICD-9-CM Code or CPT Code
Eye injury	ICD-9-CM codes 871.0-871.9
Eye surgery	CPT codes 65091-67599, 68020-68399

Coverage – Ocular Prosthetics/Surgeries

When does MAA cover ocular prosthetics?

[Refer to WAC 388-544-0500]

MAA covers medically necessary ocular prosthetics when provided by any of the following enrolled/contracted providers:

- Ophthalmologists;
- Ocularists; or
- Optometrists who specialize in orthotics.

When does MAA cover cataract surgery?

[Refer to WAC 388-544-0550 (1) and (2)]

MAA covers cataract surgery when:

- The surgery is included in the scope of care for the client's medical program;
- The surgery is medically necessary; and
- The provider clearly documents the need in the client's record.

MAA considers cataract surgery to be medically necessary when the client has:

- Correctable visual acuity in the affected eye at 20/50 or worse, as measured on the Snellen test chart; or

- One or more of the following conditions:

  - ✓ Dislocated or subluxated lens;
  - ✓ Intraocular foreign body;
  - ✓ Ocular trauma;
  - ✓ Phacogenic glaucoma;
  - ✓ Phacogenic uveitis;
  - ✓ Phacoanaphylactic endopthalmitis; or
  - ✓ Increased ocular pressure in a blind person experiencing ocular pain.

When does MAA cover surgery for strabismus?

[WAC 388-544-0550 (3)]

MAA covers strabismus surgery as follows:

- For clients 17 years of age and younger, when medically necessary. The provider must clearly document the need in the client's record;

- For clients 18 years of age and older, when:

  - ✓ The client has double vision; and
  - ✓ The surgery is not performed for cosmetic reasons.

  To receive payment for clients 18 years of age and older, providers must use MAA's expedited prior authorization process (see Section I – *Authorization* **EPA# 631**).

When does MAA cover surgery for blepharoplasty/ blepharoptosis?

[WAC 388-544-0550 (4)]

MAA covers blepharoplasty or blepharoptosis surgery for noncosmetic reasons when:

- The excess upper eyelid skin impairs the vision by blocking the superior visual field; and
- The vision is blocked to within ten degrees of central fixation using a central visual field test.

Noncovered Services

What services does MAA not cover?

[Refer to WAC 388-544-0475 and WAC 388-544-0100 (2)]

MAA does not cover the following:

- Executive style eyeglass lenses;
- Bifocal contact lenses;
- Daily and two week disposable contact lenses;
- Contact lenses prescribed for extended wear***,** except when used as therapeutic contact bandage lenses or for aphakic clients;
- Services for cosmetic purposes only;
- Glass lenses, including those that darken when exposed to light;
- Group vision screening for eyeglasses;
- Nonglare or anti-reflective lenses;
- Orthoptics and visual training therapy;
- Progressive lenses;
- Refractive surgery of any type that changes the eye's refractive error. The intent of the refractive surgery procedure is to reduce or eliminate the need for eyeglass or contact lens corrections. (This does not include intraocular lens implantation following cataract surgery);
- Sunglasses and accessories that function as sunglasses (e.g., "clip-ons");
- Upgrades at private expense to avoid MAA's contract limitation (e.g., frames that are not available through MAA's contract or noncontract frames or lenses for which the client or other person pays the difference between MAA's payment and the total cost);

MAA evaluates a request for any service that is listed as noncovered in this chapter under the provisions of WAC 388-501-0160.

MAA evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions when medically necessary, under the standards for covered services in WAC 388-501-0165.

MAA evaluates a request for a service in a covered category that has been determined to be experimental or investigational under WAC 388-531-0550, according to the provisions of WAC 388-501-0165.

***Note regarding extended wear contact lenses:** MAA's opinion is that the prolonged use of overnight wear may increase the risk of corneal swelling and ulceration. Therefore, MAA approves their use in limited situations where they are used as a therapeutic contact bandage lens or for aphakic clients.

Involuntary Treatment Act (ITA)

Physicians may provide psychiatric services under the Involuntary Treatment Act according to the following guidelines:

- Each involuntarily committed person must be examined and evaluated by a licensed physician or psychiatrist within 24 hours of admission or payment will be denied. This evaluation may be used for both treatment purposes and court testimony. Bill admissions through the emergency room using either CPT code 90801 or 90802.

- A day's rounds, along with any one of the following, constitute direct client care: narcosynthesis, brief (up to one hour) individual psychotherapy, multiple/family group therapy, group therapy, or electroconvulsive therapy.

- Payment is made if the date of service is within 30 days from the date of detention.

- An extension form is required after 20 days of care. Extension approvals can be from the Regional Support Network (RSN), as well as the state hospital.

- A court may request another physician or psychiatrist evaluation.

- The ITA form must include identification of the county of commitment, as well as some identification (signature or initials) of the County Designee completing the form. The physician or psychiatrist must complete Section I of the ITA Patient Claim Information form (DSHS 13-628x). If you need copies of this referral form, mail or fax a written request on letterhead to Department of Printing Fulfillment, Mail Stop 47100, PO Box 47100, Olympia, WA 98504-7100, fax: (360) 586-8831.

- MAA reimburses for physician and psychiatrist evaluations and consultations to the court regarding the need for continued involuntary psychiatric hospitalization of a client. Documentation of the time required for actual testimony must be maintained in the client's medical record. Only one court testimony is paid per hearing. Bill using the medical testimony code (CPT code 99075) for time spent doing court testimony.

  ☞ **Note:** One unit = 10 minutes. A maximum of five units is allowed.

- Additional costs for court testimony are reimbursed from county ITA administrative funds.

Podiatric Services [Refer to WAC 388-531-1300]

- MAA reimburses podiatrists for:

  ✓ Those procedure codes and diagnosis codes that are within their scope of practice;
  ✓ Routine foot care only when a medical condition affecting the legs or feet (such as diabetes or arteriosclerosis obliterans) requires an M.D., D.O., or podiatrist to perform this care.

  Examples of a medical condition include, but are not limited to:

  ➢ Limitation of ambulation due to mycosis.
  ➢ Likelihood that absence of treatment will result in significant medical complications.

  ✓ Those orthotics listed on pages K.5 and K.6. If PA or expedited prior authorization (EPA) is required, see Section I.

  ☞ **Note:** If the description of the orthotic code indicates the code is for a single orthotic or impression casting of one foot, either modifier RT or LT **must** be included on the claim. Providers must use an appropriate procedure code with the word "pair" in the description when billing for fabrications, casting, or impressions of both feet.

  ✓ An Evaluation and Management (E&M) code and an orthotic on the same day if the E&M service performed has a separately identifiable diagnosis and is documented in the client's medical record.

- Medicare does not reimburse for orthotics and casting. You may bill MAA directly for those services without submitting a Medicare denial, unless the client's Medical ID card indicates *QMB - Medicare only*, in which case the orthotics and casting is not covered by MAA.

- Biomechanical evaluation (the evaluation of the foot that includes various measures and manipulations necessary for the fitting of an orthotic) is included in the orthotic fee.

Limitations

- Local nerve blocks for subregional anatomic areas (such as the ankle and foot) are included in the reimbursement for the surgical procedure and are not reimbursed separately.

- Reimbursement for debridement of nails is limited to a maximum of one treatment in a 60-day period.

- MAA reimburses podiatrists for covered, diagnostic, radiologic services of the ankle and foot only when the client is examined before the x-ray is ordered.

What is not covered?

- X-rays for soft tissue diagnosis;
- Bilateral x-rays for unilateral condition;
- X-rays in excess of two views;
- X-rays that are ordered before the client is examined;
- X-rays for any part of the body other than the foot or ankle;
- Treatment of flat feet; and
- Treatment of fungal (mycotic) disease.

Radiology Services

[Refer to WAC 388-531-1450]

General Limitations on Radiology Services

The following services are not usually considered medically necessary and may be subject to post-pay review:

- X-rays for soft tissue diagnosis;
- Bilateral x-rays for a unilateral condition; and
- X-rays in excess of two views.

☞ **Note:** MAA does not reimburse for radiology services with diagnosis code V72.5. Providers must bill the appropriate medical ICD-9-CM code.

MAA does not reimburse radiology claim with diagnosis code V72.5. Providers must bill the appropriate medical ICD-9-CM diagnosis.

Other Limitations

- PET Scans and MRI/MRAs are limited to one per day.
- Multiple CT Scans are allowed only if done at different times of the day or if modifiers LT or RT are attached.
- MAA does not reimburse radiologists for after-hours service codes 99050–99054.

Contrast Material

Contrast material is not reimbursed separately, except in the case of low-osmolar contrast media (LOCM) used in intrathecal, intravenous, and intra-arterial injections for clients with one or more of the following conditions:

- A history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting.
- A history of asthma or allergy.
- Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension.
- Generalized severe debilitation.
- Sickle cell disease.

To bill for LOCM, use the appropriate HCPCS procedure codes Q9945-Q9951. The brand name of the LOCM and the dosage must be documented in the client's record.

Radiopharmaceutical Diagnostic Imaging Agents

- When performing nuclear medicine procedures, separate payment is allowed for radiopharmaceutical diagnostic imaging agents (Q9945-Q9951).

- MAA allows the following CPT codes for radiopharmaceutical therapy without PA: CPT codes 79101, 79445, and 79005.

Outpatient MRIs

You must bill using MAA's EPA process for all outpatient MRIs. See Section I.

Outpatient PET Scans

MAA does not accept HCPCS codes for PET scans EXCEPT G0331-G0331.

Providers **must** use one of the CPT codes from the range 78459, 78608, and 78811-78813 when billing for PET scans.

All outpatient PET scans require some form of authorization. The following PET scans require prior authorization: CPT codes G0030-G0031 and CPT codes 78459, 78608, and 78811-78813.

For details on prior authorization for PET scans, refer to Section I.

Mammograms

MAA has adopted the National Cancer Institute (NCI) recommendations regarding screening mammograms (CPT code 76092 and add-on code 76083). For clients age 40 and over, one annual screening mammogram is allowed. Other screening mammograms may be allowed if determined to be medically necessary and are documented in the client's record.

Radiology Modifiers for Bilateral Procedures

- Bill the procedure on two separate lines using modifier 50 on one line only.
- Bill **modifier LT or RT** on separate lines when a radiological procedure is performed on the right and/or left side or extremity.
- Do not use modifier 50, LT, or RT if the procedure is defined as bilateral.

Anesthesia for Radiological Procedures **[Refer to WAC 388-531-0300 (2) and (7)]**

General anesthesia is allowed for radiological procedures for children and/or non-cooperative clients when the medically necessary procedure cannot be performed unless the client is anesthetized.

Providers **must** use the anesthesia CPT code 01922 when providing general anesthesia for non-invasive imaging or radiation therapy. **Do not** bill the radiological procedure code (e.g., CPT code 71010) with an anesthesia modifier to bill for the anesthesia procedure. When using CPT code 01922 for non-invasive imaging or radiation therapy:

- The client must be 17 years of age or younger; or
- A statement of the client-specific reasons why the procedure cannot be performed without anesthesia services must be kept in the client's medical record and made available to MAA on request.

Nuclear Medicine

When billing MAA for nuclear medicine, the multiple surgery rules are applied when the coding combinations listed below are billed:

- For the same client, on the same day, by the same physician or by more than one physician of the same specialty in the same group practice; or
- With other codes that are subject to the multiple surgery rules, not just when billed in the combinations specified below:
  - ✓ CPT code 78306 (bone imaging; whole body) and CPT code 78320 (bone imaging; SPECT);
  - ✓ CPT code 78802 (radionuclide localization of tumor; whole body), CPT code 78803 (tumor localization; SPECT), and CPT code 78804 (radiopharmaceutic localization of tumor requiring 2 or more days); or
  - ✓ CPT code 78806 (radionuclide localization of abscess; whole body) and 78807 (radionuclide localization of abscess; SPECT).

Consultation on X-Ray Examination

When billing a consultation, the consulting physician must bill the specific x-ray code with modifier 26 (professional component).

For example: The primary physician would bill with the global chest x-ray (CPT code 71020) or the professional component (CPT code 71020-26), and the consulting physician would bill only for the professional component of the chest x-ray (e.g., CPT code 71020-26).

Portable X-Rays

- Portable x-ray services furnished in a client's home or nursing facility and payable by MAA are limited to the following:

  ✓ Skeletal films involving extremities, pelvis, vertebral column, or skull;
  ✓ Chest or abdominal films that do not involve the use of contrast media; or
  ✓ Diagnostic mammograms.

- Bill for transportation of x-ray equipment as follows:

  ✓ R0070 - If there is only one patient bill one unit;

  ✓ R0075 - If there are multiple patients, **bill one unit** per individual client's claim with one of the following modifiers, as appropriate. ***You must bill using a separate claim form for each MAA client seen.*** MAA reimburses the fee for procedure code R0075 divided by the number of clients, as outlined by the modifiers in the following table:

Procedure Code	Brief Description
R0070	Transport portable x-ray
R0075-UN	Transport port x-ray multipl-2 clients seen
R0075-UP	Transport port x-ray multipl-3 clients seen
R0075-UQ	Transport port x-ray multipl-4 clients seen
R0075-UR	Transport port x-ray multipl-5 clients seen
R0075-US	Transport port x-ray multipl-6 or more clients seen

☞ **Note:** MAA's reimbursement for procedure codes R0070 and R0075 includes setup. The fee for HCPCS code R0075 is divided among the clients served, as outlined by the modifiers indicated above. If no modifiers are used for HCPCS code R0075, the code will be denied. Do not bill HCPCS code R0070 in combination with HCPCS code R0075.

Heart Catheterizations

When a physician performs cardiac catheterization in a setting where the physician does not own the equipment (e.g., a hospital or ASC), MAA reimburses providers for the appropriate **procedure code with modifier 26 (professional component) only**. To bill using either the global or technical components, providers must have a contract with MAA certifying they perform heart catheterizations in their office and that they own their own equipment.

Use cardiac catheterization and angiography to report services individually. It is not appropriate to bill with modifier 51 (multiple procedures) with any of these codes.

Pathology and Laboratory

[Refer to WAC 388-531-0800 and WAC 388-531-0850]

Certification

Independent laboratories must be certified according to Title XVII of the Social Security Act (Medicare) to receive payment from Medicaid.

MAA reimburses laboratories for Medicare-approved tests only.

CLIA Certification

All facilities performing laboratory testing must have a Clinical Laboratory Improvement Amendment (CLIA) certificate and identification number on file with MAA in order to receive reimbursement from MAA.

To obtain a CLIA certificate and number, or to resolve questions concerning your CLIA certification, call (206) 361-2805 or write to:

Department of Health
Office of Laboratory Quality Assurance
1610 NE 150th Street
Shoreline, Washington 98155
(206) 361-2805
(206) 361-2813 FAX

Reference Laboratory

If a laboratory sends a specimen to a reference (outside) lab, you may bill for the reference lab. However, the reference lab provider number must be entered in the performing provider number field. The reference lab must be CLIA-certified and have an active CLIA identification number on file with MAA. Use modifier 90.

Cancer Screens (HCPCS codes G0101-G0107 and G0120-G0122)

HCPCS Code	Limitations	Payable Only With Diagnosis Code(s)
G0101	Females only *[Use for Pap smear professional services]*	V25.01 through V25.3, V25.40 through V25.9, and V76.2
G0102	Bundled	N/A
G0103	Males age 50 and older Once every 12 months	Any valid ICD-9-CM code other than high risk
G0105*	Clients at high risk for colorectal cancer One every 24 months Must use modifier 53 if procedure is discontinued.	High risk 555.1, 555.0, 555.2, 555.9, 556.0-556.6, 556.8, 556.9, 558.2, 558.9, V10.05, V10.06, V12.72.
G0106	Clients age 50 and older and not a high risk Once every 48 months	Any valid ICD-9-CM code other than high risk
G0107	Clients age 50 and older Once every 12 months (1-3 simultaneous determinations)	Any valid ICD-9-CM code other than high risk
G0120	Clients age 50 and older who are at high risk for colorectal cancer Once every 24 months Must use modifier 53 if procedure is discontinued.	High risk 555.1, 555.0, 555.2, 555.9, 556.0-556.6, 556.8, 556.9, 558.2, 558.9, V10.05, V10.06, V12.72.
G0121*	Once every 48 months	Any valid ICD-9-CM code other than high risk
G0122	None	Any valid ICD-9-CM code other than high risk

☞ **Note**: Per Medicare guidelines, MAA's payment is reduced when billed with modifier 53 (discontinued procedure).

Coding and Payment Policies

- Pathology and laboratory services must be provided either by a pathologist or by technologists who are under the supervision of a physician.
- Physicians must bill using their provider number for laboratory services provided by their technicians under their supervision.
- An independent laboratory and/or hospital laboratory must bill using its provider number for any services performed in its facility.
- MAA reimburses for one blood draw fee (CPT code 36415-36416, or 36540) per day.
- MAA reimburses for one catheterization for collection of a urine specimen (HCPCS code P9612) per day.
- CPT codes 85007, 85009, 85014, 85018, 85021, 85027, 85041, and 85048 are included in the complete blood count procedure.
- CPT codes 81001-81003 and 81015 are not allowed in combination with urinalysis procedure 81000.
- CPT codes 86812-86822 are limited to a maximum of 15 tests total for human leukocyte antigens (HLA) typing per client, per lifetime.
- Do not bill with modifier 26 if the description in CPT indicates professional services only.
- Reimbursement for lab tests includes handling, packaging and mailing fee. Separate reimbursement is not allowed.

Note: Laboratory claims must include an appropriate medical diagnosis code. The ordering provider must give the appropriate medical diagnosis code to the performing laboratory at the time the tests are ordered. **MAA does not reimburse a laboratory for procedures billed using ICD-9-CM diagnosis codes V72.5 and V72.6.**

Drug Screens

MAA reimburses for drug screens only when:

- ✓ Medically necessary and ordered by a physician as part of a medical evaluation; or
- ✓ Drug and alcohol screens are required to assess suitability for medical tests or treatment.

- MAA does not reimburse for drug screens to monitor any of the following:
  - ✓ Program compliance in either a residential or outpatient drug or alcohol treatment program;
  - ✓ Drug or alcohol use by a client when the screen is performed by a provider in a private practice; or
  - ✓ Suspected drug use by clients living in a residential setting such as a group home.
- For clients in the Division of Alcohol and Substance Abuse (DASA) contracted methadone treatment programs, drug screens are reimbursed through a contract issued by DASA, not through MAA.

Laboratory Services Referred by Community Mental Health Center (CMHC) or DASA-Contracted Providers

When CMHC or DASA-contracted providers refer clients enrolled in an MAA managed care plan for laboratory services, the laboratory **must bill MAA directly.** The following conditions apply:

- The laboratory service is medically necessary;
- The laboratory service is **directly** related to the client's mental health or alcohol and substance abuse;
- The laboratory service is referred by a CMHC or DASA-contracted provider who has a core provider agreement with MAA; and
- The laboratory must bill with a mental health, substance abuse, or alcohol abuse diagnosis.

To bill for laboratory services, laboratories **must** put the seven-digit CMHC or DASA-contracted referring provider identification number assigned by MAA in the “referring provider” field of the claim form.

CMHC and DASA-contracted services are excluded from MAA’s managed care contracts.

Automated Multi-Channel Tests

MAA reimburses for CPT lab panel codes 80048, 80050, 80051, 80053, 80061, 80069, and 80076. The individual automated multi-channel tests are:

Procedure Code	Brief Description
82040	Albumin; serum
82247	Bilirubin; total
82248	Bilirubin; direct
82310	Calcium; total
82374	Carbon dioxide (bicarbonate)
82435	Chloride; blood
82465	Cholesterol, serum, total
82550	Creatine kinase (CK)
82565	Creatine; blood
82947	Glucose; quantitative
82977	Glutamyltransferase, gamma (GGT)
83615	Lactate dehydrogenase (LD) (LDH)
84075	Phosphatase, alkaline
84100	Phosphorous inorganic (phosphate)
84132	Potassium; serum
84155	Protein; total, except refractometry
84295	Sodium; serum
84450	Transferase; apartate amino (AST)(SGOT)
84460	Transferase; alanine amino (AST)(SGPT)
84478	Tryglycerides
84520	Urea nitrogen; quantitative
84550	Uric acid; blood
85004	Automated diff wbc count
85007	B1 smear w/diff wbc count
85009	Manual diff wbc count b-coat
85027	Complete cbc, automated

- You may bill a combination of panels and individual tests not included in the panel. ***However, do not bill separately for any individual tests that are included in the panel.*** Duplicate tests will be denied. Panel codes must be billed if all individual tests in the panel are performed.

- Each test and/or panel must be billed on a separate line.

- All automated/non-automated tests must be billed on the same claim form when performed for a client by the same provider on the same day. For laboratory services that exceed the lines allowed per claim, see below.

Billing for laboratory services that exceed the lines allowed

- Providers who bill on hardcopy HCFA-1500 claim forms are allowed up to 6 lines per claim. Direct entry, magnetic tape, or electronic submitters are allowed 50 lines per claim. **Use additional claim forms if the services exceed the lines allowed**. Enter the statement: "Additional services" in field 19 when billing on a hardcopy HCFA-1500 claim form or in the *Comments* section when billing electronically. Total each claim separately.

- If MAA pays a claim with one or more automated/non-automated lab tests, providers must bill any additional automated/non-automated lab tests for the same date of service on an Adjustment Request form [DSHS# 525-109]. Refer to the Important Contacts section for ordering/downloading DSHS forms. Make sure you adjust the claim with the paid automated/non-automated lab tests using the comment "**additional services.**"

Reimbursement for Automated Multi-Channel Tests

For individual automated multi-channel tests, providers are paid on the basis of the total number of individual automated multi-channel tests performed for the same client, on the same day, by the same laboratory.

- When all the tests in a panel are not performed, each test must be billed as a separate line item on the claim form.
- When there are additional automated multi-channel tests not included in a panel, each additional test must be billed as a separate line item on the claim form.
- Bill any other individual tests as a separate line item on the claim form.

Payment calculation for individual automated laboratory tests is based on the total number of automated multichannel tests performed per day, per patient. Reimbursement for each test is based on Medicare's fees multiplied by MAA's fiscal year laboratory conversion factor.

For example:

- If five individual automated tests are billed, the reimbursement is equal to the internal code's maximum allowable fee.
- If five individual automated tests and a panel are billed, MAA reimburses providers separately for the panel at the panel's maximum allowable. Reimbursement for the individual automated tests, less any duplicates, is equal to the internal code's maximum allowable fee.

If one automated multi-channel test is billed, reimbursement is at the individual procedure code or internal code's maximum allowable fee, whichever is lower. The same applies if the same automated multi-channel test is performed with modifier 91 (see page E.19 for information on modifier 91).

Non-automated Multi-Channel

Organ and disease panels (CPT codes 80055 and 80074) do not include automated multi-channel tests. If all individual tests in the panel are not performed, reimbursement is the individual procedure code maximum allowable fee or billed charge, whichever is lower.

The non-automated multi-channel tests are:

CPT Code	Brief Description
83718	Assay of lipoprotein
84443	Assay thyroid stim hormone
85025	Automated hemogram
85651	Rbc sed rate, nonautomated
86255	Fluorescent antibody, screen
86430	Rheumatoid factor test
86592	Blood serology, qualitative
86644	CMV antibody
86694	Herpes simplex test
86705	Hep b core antibody, test
86709	Hep a antibody, igm
86762	Rubella antibody
86777	Toxoplasma antibody
86803	Hep c ab test, confirm
86850	RBC antibody screen
86900	Blood typing, ABO
86901	Blood typing, Rh(D)
87340	Hepatitis b surface ag, eia

Laboratory Modifiers

Modifier QP

Modifier QP indicates documentation is on file showing that the lab test(s) was ordered individually or ordered as a CPT-recognized panel, other than automated profile CPT codes 80002-80019, G0058, G0059, and G0060. MAA recognizes this modifier as ***informational only***. **This modifier is *not* appropriate to use for billing repeat tests or to indicate the test was not done as a panel.**

Modifier 90

Reference (Outside) Laboratory: When a laboratory sends a specimen to a reference (outside) laboratory, the referring laboratory may bill for the reference laboratory (pass-through billing) by adding modifier 90 to the laboratory procedure code. *The reference laboratory provider number must be entered in the performing number field on the claim form. Both labs must be CLIA-certified.*

Modifier 91

Repeat Clinical Laboratory Diagnostic Test

Add modifier 91 to the laboratory procedure code when it is necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results.

Do not use this modifier when tests are rerun:

- To confirm initial results;
- Due to testing problems with specimens or equipment;
- For any reason when a normal, one-time, reportable result is all that is required; or
- When there are standard procedure codes available that describe the series of results (e.g., glucose tolerance test, evocative/suppression testing, etc.).

Modifier 91 affects payments. Duplicate tests billed on the same day for the same client will be denied unless modifier 91 is used.

Clinical Laboratory Codes

Some clinical laboratory codes have both a professional component and a technical component. If performing only the technical component, do not bill with a modifier. The professional component for physician interpretation must be billed using modifier 26. Laboratories performing both the professional and the technical components must bill the code without a modifier for the technical and with modifier 26 for the professional. These services may be billed either on separate lines or on separate claim forms. Refer to MAA's fee schedule (section J) for those codes with both a technical and professional component.

Pap Smears

For professional services related to Pap smears, refer to the Cancer Screens Section (page E.13).

- Use CPT codes 88147-88154, 88164-88167, and P3000-P3001 for conventional Pap smears.

- MAA reimburses for thin layer preparation CPT codes 88142-88143 and 88174-88175. MAA does not reimburse providers for HCPCS codes G0123-G0124 and G0141-G0148. MAA reimburses for thin layer Paps at Medicare's payment levels. Thin layer preparation and conventional preparation CPT codes cannot be billed in combination.

- Use CPT codes 88141 and 88155 in conjunction with codes 88142-88143 and 88164-88167.

- Use the appropriate medical diagnosis if a condition is found.

- MAA reimburses providers for one routine Pap smear per client, per calendar year only. MAA considers routine Pap smears to be those billed with an ICD-9-CM diagnosis of V76.2. Any additional routine Pap smears will be denied.

- MAA does not reimburse providers for CPT code 88112 with diagnosis V72.3 or V76.2.

HIV Testing

MAA reimburses providers for HIV testing (CPT codes 87534-87539) for ICD-9-CM diagnosis codes 042 or V08 only.

STAT Lab Charges

When the laboratory tests listed on the following page are performed on a STAT basis, the provider may bill **HCPCS code S3600** (Stat laboratory request).

- Reimbursement is limited to one STAT charge per episode (not once per test).
- Tests must be ordered STAT and payment is limited to only those that are needed to manage the client in a true emergency.
- The laboratory report must contain the name of the provider who requested the STAT.
- The medical record must reflect the medical necessity and urgency of the service.

Note: "STAT" must be clearly indicated by the provider and must be documented in the laboratory report and the client's record. Tests generated from the emergency room do not automatically justify a STAT order. Use **HCPCS code S3600** with the procedure codes on the following page.

The STAT charge is paid only with the tests listed below:

Procedure Code	Brief Description
G0306	CBC/diffwbc w/o platelet
G0307	CBC without platelet
80048	Basic metabolic panel
80051	Electrolyte panel
80069	Renal function panel
80076	Hepatic function panel
80100	Drug screen, qualitate/multi
80101	Drug screen, single
80156	Assay, carbamazepine, total
80162	Assay of digoxin
80164	Assay, dipropylacetic acid
80170	Assay of gentamicin
80178	Assay of lithium
80184	Assay of phenobarbital
80185	Assay of phenytoin, total
80188	Assay primidone
80192	Assay of procainamide
80194	Assay of procainamide
80196	Assay of salicylate
80197	Assay of tacrolimus
80198	Assay of theophylline
81000	Urinalysis, nonauto w/scope
81001	Urinalysis, auto w/scope
81002	Urinalysis, nonauto w/o scope
81003	Urinalysis, auto, w/o scope
81005	Urnalysis
82003	Assay of acetaminophen
82009	Test for acetone/ketones
82040	Assay of serum albumin
82055	Assay of ethanol
82150	Assay of amylase
82247	Bilirubin; total
82248	Bilirubin; direct
82310	Assay of calcium
82330	Assay of calcium
82374	Assay, blood carbon dioxide
82435	Assay of blood chloride
82550	Assay of ck (cpk)
82565	Assay of creatinine
82803	Blood gases: pH, pO2 & pCO2
82945	Glucose other fluid
82947	Assay, glucose, blood quant
83615	Lactate (LD) (LDH) enzyme
83663	Test urine for lactose

Procedure Code	Brief Description
83735	Assay of magnesium
83874	Assay of myoglobin
83880	Natriuretic peptide
84100	Assay of phosphorus
84132	Assay of serum potassium
84155	Assay of protein
84157	Assay of protein, other
84295	Assay of serum sodium
84302	Assay of sweat sodium
84450	Transferase (AST)(SGOT)
84484	Assay of troponin, quant
84512	Troponin qualitative
84520	Assay of urea nitrogen
84550	Assay of blood/uric acid
84702	Chorionic gonadotropin test
85004	Automated diff wbc count
85007	Differential WBC count
85027	Automated hemogram
85032	Manual cell count, each
85046	Automated hemogram
85049	Automated platelet count
85378	Fibrin degradation
85380	Fibrin degradation, vte
85384	Fibrinogen
85396	Clotting assay, whole blood
85610	Prothrombin time
85730	Thromboplastin time, partial
86308	Heterophile antibodies
86403	Particle agglutination test
86880	Coombs test
86900	Blood typing, ABO
86901	Blood typing, Rh (D)
86920	Compatibility test
86921	Compatibility test
86922	Compatibility test
86971	RBC pretreatment
87205	Smear gram stain
87210	Smear, wet mount, saline/ink
87281	Pneumocystis carinii, ag, if
87327	Cryptococcus neoform ag, eia
87400	Influenza a/b, ag, eia
89051	Body fluid cell count

This page intentionally left blank.

Consultations

If another provider refers a client during her pregnancy for a consultation, bill MAA using consultation CPT codes 99241-99255. If a follow-up inpatient consultation is necessary, bill using CPT codes 99261-99263. You **must** list the referring physician's name and MAA-assigned provider number in the "Referring Physician" field on the claim form.

If the consultation results in the decision to perform surgery (i.e. a cesarean section), MAA reimburses the consulting physician for the consultation as follows:

- If the consulting physician does not perform the cesarean section, bill MAA the appropriate consultation code.

- If the consulting physician performs the cesarean section and does the consultation **two or more days prior to the date of surgery**, bill MAA the appropriate **consultation code with modifier 57** (e.g. 99241-57).

MAA does not reimburse the consulting physician if the following applies:

- If the consulting physician performs the cesarean section and does the consultation **the day before or the day of the cesarean section**, the consultation is bundled within payment for the surgery. **Do not bill** MAA for the consultation in this situation.

Bill consultations with an appropriate ICD-9-CM medical diagnosis code. You must demonstrate the medical necessity (i.e. sign, symptom, or condition). MAA does not reimburse providers for a consultation with a normal pregnancy diagnosis code (e.g. V22.0-V22.2).

MAA reimburses consulting OB/GYN providers for an external cephalic version (CPT code 59412) and a consultation when performed on the same day.

General Obstetrical Payment Policies and Limitations

- MAA reimburses a multiple vaginal delivery (for twins, triplets, etc.) at 100% for the first baby. When billing for the second or third baby, you must bill using the delivery-only code (CPT code 59409 or 59612) for each additional baby. Reimbursement for each additional baby will be 50% of the delivery-only code's maximum allowance. Bill each baby's delivery on a separate line. Identify on the claim form as "twin A" or "twin B," etc.

- MAA reimburses for multiple births by cesarean delivery at 100% for the first baby. No additional reimbursement will be made for additional babies.

- A physician may bill for an assist at c-section by adding modifier 80, 81, or 82 to the delivery only code (e.g. 59514-80). Reimbursement is 20% of the delivery-only code's maximum allowance.

- Physician assistants (PA) must bill for an assist at c-section **on the same claim form** as the physician performing the delivery by adding modifier 80, 81, or 82 to the delivery-only code (e.g. 59514-80). The claim must be billed using the delivering physician's provider number.

- RNFAs assisting at c-sections may **only** bill using CPT code 59514 or 59620 with modifier 80.

- To bill for anesthesia during delivery, see the Anesthesia Section (page F.26).

- For deliveries in a birthing center, refer to MAA's current *Births in Birthing Centers Billing Instructions*. For deliveries in a home birth setting, refer to MAA's current *Planned Home Births Billing Instructions.*

☞ **Note**: Maternity Support Services/Infant Case Management (MSS/ICM) is a program designed to help pregnant women and their newborns gain access to medical, social, educational and other services. This program provides a variety of services for both the woman and/or her child in the home or clinic throughout pregnancy and up to 60 days after delivery. For information on MSS/ICM, call MAA's Family Services Section at (360) 725-1655.

For your convenience, a table summarizing "Billing MAA for Maternity Services" is included on the following pages.

Chemotherapy Services [Refer to WAC 388-531-0950(11)]

Chemotherapy Administration

MAA has adopted the following HCPCS codes (listed below) for chemotherapy administration. These codes may not be billed in addition to the current CPT codes for these procedures. Claims billed for the same date of service with both the HCPCS codes and the CPT codes ***will be denied.***

HCPSC Procedure Code	CPT Crosswalk Procedure Codes	Brief Description
G0345	90780	IV infuse hydration, initial
G0346	90781	Each additional infuse hour
G0347	90780	IV infusion therapy/diagnost
G0348	90781	Each additional hr up to 8hr
G0349	90781	Additional sequential infuse
G0350	N/A	Concurrent infusion
G0351	90782	Therapeutic/diagnostic injec
G0353	90784	IV push,single orinitial dru
G0354	N/A	Each addition sequential IV
G0355	96400	Chemo adminisrate subcut/IM
G0356	96400	Hormonal anti-neoplastic
G0357	96408	IV push single/initial subst
G0358	96408	IV push each additional drug
G0359	96410	Chemotherapy IV one hr initi
G0360	96412	Each additional hr 1-8 hrs
G0361	96414	Prolong chemo infuse>8hrs pu
G0362	96412	Each add sequential infusion
G0363	N/A	Irrigate implanted venous de

You may bill chemotherapy administration (CPT code 96408) for each drug administered or bill HCPCS code G0357 for the initial drug administration and G0358 for each additional drug.

MAA does not reimburse for CPT code 99211 on the same date of service as drug administration codes G0345 – G0349, G0351 – G0353, and G0355 – G0362 , 90780 – 90788, 96400, 96408 – 96425, 96520, or 96530. If billed in combination, MAA will deny the E&M code 99211. However, providers may bill other E&M codes on the same date of service utilizing modifier 25 to indicate that a significant and separately identifiable E&M service was provided. If modifier 25 is not utilized, MAA will deny the drug administration code.

Chemotherapy Drugs

The following reimbursement guidelines apply to chemotherapy drugs (HCPCS codes J9000-J9999):

- MAA's maximum allowable fee per unit is based on the HCPCS description of the chemotherapy drug.

- MAA's maximum allowable fee is equal to Medicare's drug methodology of 106% of the average sales price. If a Medicare fee is unavailable for a particular drug, MAA will continue to price the drug at 86% of average wholesale price (AWP).

- Preparation of the chemotherapy drug is included in the administration of the drug.

Billing for Single-Dose Vials:

For single-dose vials, bill the total amount of the drug contained in the vial(s), including partial vials. Based on the unit definition for the HCPCS code, MAA reimburses providers for the total number of units contained in the vial. **For example:**

> If a total of 150 mg of Etoposide is required for the therapy, and two 100 mg single dose vials are used to obtain the total dosage, then the total of the two 100 mg vials is reimbursed. In this case, the drug is billed using HCPCS code J9181 (Etoposide, 10 mg). If MAA's maximum allowable fee is $4.38 per 10 mg unit, the total allowable is $87.60 (200 mg divided by 10 = 20 units x $4.38).

Billing for Multi-Dose Vials:

For multi-dose vials, bill **only** the amount of the drug administered to the client. Based on the unit definition (rounded up to the nearest whole unit) of the HCPCS code, MAA reimburses providers for only the amount of drug administered to the client. **For example:**

> If a total of 750 mg of Cytarabine is required for the therapy, and is taken from a 2,000 mg multi-dose vial, then only the 750 mg administered to the client is reimbursed. In this case, the drug is billed using HCPCS code J9110 (Cytarabine, 500 mg). If MAA's maximum allowable fee is $23.75 per 500 mg unit, the total allowable is $47.50 [750 mg divided by 500 = 2 (1.5 rounded) units x $23.75].

Unlisted Drugs:

When it is necessary to bill MAA for a chemotherapy drug using an unlisted drug code, you must report the National Drug Code (NDC) of the drug administered to the client. MAA uses the NDC when unlisted drug codes are billed in order to appropriately price the claim. Claims *must* be billed with the following:

- The dosage given to the client;
- The 11-digit NDC; and.
- One unit of service.

For claims billed using a paper HCFA-1500 claim form, list the required information in field 19 of the claim form.

For claims billed using an electronic HCFA-1500 claim form, list the required information in the *Comments* section of the claim form.

For claims billed using an electronic 837P claim form, list the required NDC information in DRUG IDENTIFICATION Loop 2410, LIN02, and LIN03. List the dosage given to the client in the *Comments* section of the claim form.

Note: If there is an assigned HCPCS code for the administered drug, you **must bill** MAA using the appropriate HCPCS code. ***DO NOT*** use an unlisted drug code to bill for a drug that has an assigned HCPCS code. MAA will recoup payment for any drugs paid using an unlisted drug code if an assigned HCPCS code exists for the administered drug.

Invoice Requirements

A copy of the manufacturer's invoice showing the **actual acquisition cost** of the drug must be attached to the claim ***ONLY*** when billed charges exceed $1,100.00 per line item. If billed charges are less than $1,100.00 per line item, ***DO NOT*** attach the invoice or any other paperwork to your claim. If needed, MAA will request any other necessary documentation after receipt of the claim.

This requirement applies to **all drugs** administered in the provider's office, including those drugs with an assigned CPT or HCPCS code, and those drugs billed using either unlisted drug code J3490 or J9999.

A copy of any manufacturer's invoices for all drugs (regardless of billed charges) must be maintained in the client's record and made available to MAA upon request.

Oral Anti-Emetic Drugs

In order to bill MAA for oral anti-emetic drugs (HCPCS codes Q0163-Q0181) the drug must be:

- Part of a chemotherapy regimen;
- Administered or prescribed for use immediately before, during, or within 48 hours after administration of the chemotherapy drug;
- Billed using one of the ICD-9-CM diagnosis codes 140.0-239.9 (excluding 210.0-229.9) or V58.1; and
- Submitted on the same claim form with one of the chemotherapy drug codes (HCPCS codes J8530-J9999).

Hydration Therapy with Chemotherapy

Intravenous (IV) infusion of saline (CPT codes 90780-90781 or HCPCS codes G0345-G0346) is not reimbursed separately when administered at the same time as chemotherapy infusion (CPT codes 96410, 96412, or 96414 or HCPCS codes G0359 or G0361). Separate reimbursement is allowed for IV infusion when administered separately from the chemotherapy infusion. In this case, bill using the IV infusion code with modifier 59.

Surgical Services **[Refer to WAC 388-531-1700]**

Global surgery reimbursement includes all the following services:

- The surgical procedure;
- For major surgeries (90-day global period), preoperative visits (all sites of service) that occur the day before or the day of the surgery;
- For minor surgeries (less than 90-day global period), preoperative visits (all sites of service) that occur on the day of surgery;
- Services by the primary surgeon (all sites of service) during the postoperative period;

- Postoperative dressing changes, including:

  - ✓ Local incision care and removal of operative packs;
  - ✓ Removal of cutaneous sutures, staples, lines, wires, tubes, drains and splints;
  - ✓ Insertion, irrigation and removal of urinary catheters, routine peripheral IV lines, nasogastric and rectal tubes; and
  - ✓ Change and removal of tracheostomy tubes.

- Additional medical or surgical services required because of complications that do not require additional operating room procedures.

> ☞ **Note:** Casting materials are not part of the global surgery policy and are paid separately.

Global Surgery Reimbursement

- The global surgery reimbursement period applies to any provider who participates in the surgical procedure. These providers include:

  - ✓ The surgeon;
  - ✓ The assistant surgeon (modifiers 80, 81, or 82);
  - ✓ Two surgeons (modifier 62);
  - ✓ Team surgeons (modifier 66); and
  - ✓ Anesthesiologists and CRNAs.

- The following procedure codes are bundled within the payment for the surgical procedure during the global period:

Procedure Code	Summary of Description
E&M Services	
99211-99223	Office visits, initial hospital observation care, and initial hospital inpatient care.
99231-99239	Subsequent hospital care, observation or inpatient care services, and hospital discharge services.
99241-99245	Office consultations
99251-99255	Initial inpatient consultations
99261-99263	Follow-up inpatient consultations
99271-99275	Confirmatory consultations
99291-99292	Critical care services.
99301-99303	Comprehensive nursing facility assessments
99311-99316	Subsequent nursing facility care
99331-99333	Domiciliary, rest home, or custodial care services
99347-99350	Home services
99374-99377	Care plan oversight services
Ophthalmological Services	
92012-92014	General ophthalmological services

The E&M codes listed above may be allowed if there is a separately identifiable reason for the additional E&M service unrelated to the surgery. In these cases, the E&M code must be billed with one of the following modifiers:

Modifier	**Description**
24	Unrelated E&M service by the same physician during a postoperative period (reason for the E&M service must be unrelated to the procedure)
25	Significant, separately identifiable E&M service by the same physician on the same day of a procedure (reason for the E&M service must be unrelated to the procedure)
57	Decision for surgery (only applies to surgeries with a 90-day global period)
79	Unrelated procedure or service by the same physician during the postoperative period

- Professional inpatient services (CPT codes 99221-99223) are payable only during the global follow-up period if they are performed on an emergency basis (i.e. they are not payable for scheduled hospital admissions).

- Bundled procedure codes are not payable during the global surgery reimbursement period.

- A provider (other than the surgeon) who provides all postoperative care (including all inpatient postoperative care) before discharge, must bill subsequent hospital care codes (CPT codes 99231-99233) for the inpatient hospital care, and the surgical code with modifier 55 for the post-discharge care. The surgeon must bill the surgery code with modifier 54.

- Providers who perform only the follow-up services for minor procedures performed in emergency departments must bill the appropriate level E&M code. These services are not included in the global surgical reimbursement.

- The provider who performs the emergency room service must bill for the surgical procedure without using modifier 54.

- Preoperative and postoperative critical care services provided during a global period for a seriously ill or injured client are not considered related to a surgical procedure and are paid separately when all of the following apply:

  - ✓ The client is critically ill or injured and requires the constant attendance of the provider;
  - ✓ The critical care is unrelated to the specific anatomic injury or general surgical procedure performed; and
  - ✓ The client is potentially unstable or has conditions that could pose a significant threat to life or risk of prolonged impairment.

  Bill the appropriate critical care codes with either modifier 24 or 25.

- MAA allows separate reimbursement for:

  - ✓ The initial evaluation to determine need for surgery;
  - ✓ Preoperative visits that occur two or more days before the surgery;
  - ✓ Postoperative visits for problems unrelated to the surgery;
  - ✓ Postoperative visits for services that are not included in the normal course of treatment for the surgery; and
  - ✓ Services of other providers, except when more than one provider furnishes services that are included in a global package (see modifiers 54 and 55).

Registered Nurse First Assistants (RNFA)

Registered Nurse First Assistants (RNFAs) are allowed to assist at surgeries within their scope of practice. Use modifier 80 to bill MAA for these services. Current RNFA providers who want to assist at surgeries need to submit their Certification as a Certified Nurse Operating Room (CNOR) from the Certification Board Perioperative Nursing to:

Provider Enrollment
PO Box 45562
Olympia, Washington 98504-5562

New RNFA providers must meet the following criteria:

- Licensed in Washington State as a Registered Nurse in good standing;
- Work under the direct supervision of the performing surgeon; and
- Submit the following documentation to MAA along with the Core Provider Agreement:

  - ✓ Certification as a Certified Nurse Operating Room (CNOR) from the Certification Board Perioperative Nursing;
  - ✓ Proof of Allied Health Personnel privileges in the hospital where the surgeries are performed; and
  - ✓ Certification as an RNFA from the Certification Board of Perioperative Nursing.

RNFAs who are current providers or who wish to bill only for cesarean sections (CPT codes 59514 and 59620) **do not need** to submit the Certification as an RNFA from the Certification Board Perioperative Nursing.

Multiple Surgeries

When multiple surgeries are performed on the same client, during the same operative session, MAA reimburses providers as follows:

- 100% of MAA's maximum allowable fee for the most expensive procedure; plus,
- 50% of MAA's maximum allowable fee for each of the second through the fifth procedures.

To expedite payment of your claims, bill all surgeries performed during the same operative session on the same claim.

If a partial payment is made on a claim with multiple surgeries, you must adjust your paid claim using a DSHS Adjustment Request form (DSHS 525-109). Refer to Important Contacts page for information on ordering/downloading DSHS forms.

Endoscopy Procedures

Endoscopy procedures are paid as follows:

- When multiple endoscopies from the same endoscopy group are performed on the same day, the procedure with the highest maximum allowable fee is paid the full amount. The second, third, etc., are paid at the maximum allowable amount minus the base endoscopy procedure's allowed amount.

- When multiple endoscopies from different endoscopy groups are billed, the multiple surgery rules detailed above apply.

- When payment for other procedures within an endoscopy group is less than the endoscopy base code, no payment is made.

- MAA does not reimburse for an E&M visit on the same day as the diagnostic or surgical endoscopy procedure unless there is a separately identifiable service unrelated to the endoscopy procedure. If appropriate, bill the E&M code with modifier 25.

Other Surgical Policies

- Use modifiers 80, 81 and/or 82 to bill for an assistant surgeon. An assist at major surgery is paid at 20% of the surgical procedure's maximum allowable fee. The multiple surgery rules apply for surgery assists.

- A properly completed consent form must be attached to all claims for sterilization and hysterectomy procedures (see Section H).

- MAA reimburses for the use of an operating microscope (CPT code 69990) only when billed with one of the following CPT codes:

  - ✓ 61304-61546;
  - ✓ 61550-61711;
  - ✓ 62010-62100;
  - ✓ 63081-63308;
  - ✓ 63704-63710; or
  - ✓ 64831-64907.

- The surgeries listed in the following table are limited as follows:

CPT Code(s)	Description	Limitations
11960	Insertion of tissue expander(s)	Limited to ICD-9-CM diagnoses: ✓ V10.3; ✓ 140.0-239.9; ✓ 757.6; ✓ 759.4; ✓ 906.5-906.9; or, ✓ 940.0-949.5.
11970	Replace tissue expander	
11971	Remove tissue expander(s)	
19160	Removal of breast tissue	
19162	Remove breast tissue, nodes	
19180	Removal of breast	
19182	Removal of breast	
19316	Suspension of breast	
19340	Immediate breast prosthesis	
19342	Delayed breast prosthesis	
19350	Breast reconstruction	
19357	Breast reconstruction	
19361	Breast reconstruction	
19364	Breast reconstruction	
19366	Breast reconstruction	
19367	Breast reconstruction	
19368	Breast reconstruction	
19369	Breast reconstruction	
19370	Surgery of breast capsule	
19371	Removal of breast capsule	
19380	Revise breast reconstruction	

- Subcutaneous hormone pellet implantation (CPT code 11980) is payable only with ICD-9-CM diagnosis codes 174.0-174.9 or 257.2.

- Salpingostomies (CPT codes 58673 and 58770) are payable only for a tubal pregnancy (ICD-9-CM diagnosis code 633.10, and 633.11).

- Modifier 53 must be used when billing for incomplete colonoscopies (CPT code 45378, or HCPCS codes G0105 or G0121). Do not bill incomplete colonoscopies as sigmoidoscopies. Modifier 53 indicates that the physician elected to terminate a surgical procedure. Use of modifier 53 is allowed for all surgical procedures. Modifier 53 is a payment modifier when used with CPT code 45378 or HCPCS codes G0105 or G0121 only. It is "informational only" for all other surgical procedures.

Epiphyseal

Epiphyseal surgical procedures (CPT codes 25450, 25455, 27185, 27475, 27477-27485, 27742, and 27730-27740) are allowed only for clients age 17 and younger.

Closure of Enterostomy

Mobilization of splenic flexure (CPT code 44139) is not reimbursed when billed with enterostomy procedures (CPT codes 44625 and 44626). CPT code 44139 must be used only in conjunction with partial colectomy (CPT codes 44140 through 44147).

Angioscopy

MAA reimburses for one unit of angioscopy (CPT code 35400), per session.

Apheresis

Therapeutic apheresis (CPT codes 36511-36512) includes payment for all medical management services provided to the client on the date of service. MAA reimburses for only one unit of either CPT code per client, per day, per provider.

Separate payment is not allowed for the following procedures on the same date that therapeutic apheresis services are provided, unless they are billed with modifier 25:

- Established patient office and other outpatient visits (CPT codes 99211-99215);
- Subsequent hospital care (CPT codes 99231-99233); and
- Follow-up inpatient consultations (CPT codes 99261-99263).

Do not bill apheresis management when billing for critical care time (CPT codes 99291-99292).

Urology

Circumcisions (CPT codes 54152 and 54161)

Circumcisions are covered when billed with one of the following diagnoses:

- Phimosis (ICD-9-CM 605);
- Balanoposthitis (ICD-9-CM 607.1); or
- Balnitis Xerotica (ICD-9-CM 607.81).

Urinary Tract Implants

Prior to inserting a urinary tract implant (CPT code 51715), the provider must:

- Have urology training in the use of a cystoscope and must have completed a urinary tract implant training program for the type of implant used.
- Document that the client has shown no incontinence improvement through other therapies for at least 12 months prior to collagen therapy.
- Administer and evaluate a skin test for collagen sensitivity (CPT code 95028) over a four-week period prior to collagen therapy. A negative sensitivity must be documented in the client's record.

Refer to Section K for those urinary tract implants covered by MAA. **All services provided and implant codes must be billed on the same claim form**

Urological Procedures with Sterilizations in the Description

These procedures may stop in MAA's payment system as a result of MAA's effort to remain in compliance with federal sterilization consent form requirements. If the surgery is not being done for the purpose of sterilization, or the sterilizing portion of the procedure is not being performed, a sterilization consent form is not required. However, you must note one of the following in the *Comments* section of your claim:

- Not sterilized; or
- Not done primarily for the purpose of sterilization.

Indwelling Catheter

- Separate payment is allowed for insertion of a temporary, indwelling catheter when it is used to treat a temporary obstruction and is performed in a physician's office.
- Bill for the insertion of the indwelling catheter using CPT code 51702 or 51703.
- MAA reimburses providers for insertion of an indwelling catheter only when performed in an office setting.
- Insertion of an indwelling catheter is bundled when performed on the same day as a major surgery.
- Insertion of an indwelling catheter is bundled when performed during the post-operative period of a major surgery.

Bilateral Procedures

- If a procedure is done bilaterally and is not identified by its terminology as a bilateral procedure, bill the procedure with modifier 50. Bill as a single line item on the claim.
- If a procedure is done bilaterally and is identified by its terminology as bilateral (e.g. CPT codes 27395 or 52290), do not bill the procedure with modifier 50.
- Use modifiers LT and RT to indicate left and right for unilateral procedures.

Pre-/Intra-/Postoperative Payment Splits

Pre-, intra-, and postoperative payment splits are made when modifiers 54, 55, and 56 are used.

MAA has adopted Medicare's payment splits, as listed below. If Medicare has not assigned a payment split to a procedure, MAA uses a payment split of 10% / 80% / 10%.

Code Range	Operative System	Pre-	Intra-	Postoperative
10000 - 19499	Integumentary	10%	71%	19%
20000 - 29909	Musculoskeletal	10%	69%	21%
30000 - 32999	Respiratory	10%	76%	14%
33010 - 37788	Cardiovascular	09%	84%	07%
37790 - 37799	Cardiovascular	08%	83%	09%
38100 - 38115	Hemic/Lymphatic	11%	73%	16%
38120 - 38300	Hemic/Lymphatic	09%	84%	07%
38305 - 38999	Hemic/Lymphatic	11%	73%	16%
39000 - 39599	Mediastinum/Diaphragm	09%	84%	07%
40490 - 43641	Digestive	09%	81%	10%
43651 - 43652	Digestive	11%	76%	13%
43653 - 49999	Digestive	09%	81%	10%
50010 - 53899	Urinary	08%	83%	09%
54000 - 55980	Male Genital	10%	80%	10%
56300 - 56399	Laparoscopy/Hysteroscopy	09%	81%	10%
56405 - 58999	Female Genital	12%	74%	14%
59000 - 59899	Maternity	17%	60%	23%
60000 - 60605	Endocrine	09%	82%	09%
60650 - 60699	Endocrine	09%	84%	07%
61000 - 64999	Nervous System	11%	76%	13%
65091 - 68899	Eye/Occular	10%	70%	20%
69000 - 69979	Auditory	07%	79%	14%

Anesthesia [Refer to WAC 388-531-0300]

General Anesthesia

- MAA requires providers to use anesthesia CPT codes 00100-01999 to bill for anesthesia services paid with base and time units. Do **not use** the surgical procedure code with an anesthesia modifier to bill for the anesthesia procedure.

- MAA reimburses for CPT code 01922 for noninvasive imaging or radiation therapy when:

  - ✓ The client is 17 years of age or younger; or
  - ✓ There are client-specific reasons why the procedure cannot be performed without anesthesia services. Documentation must be kept in the client's medical record.

- MAA reimburses providers for covered anesthesia services performed by one of the following:

  - ✓ Anesthesiologist;
  - ✓ Certified registered nurse anesthetist (CRNA); or
  - ✓ Other providers who have a contract with MAA to provide anesthesia services.

- For each client, the anesthesia provider must:

  - ✓ Perform a pre-anesthetic examination and evaluation;
  - ✓ Prescribe the anesthesia plan;
  - ✓ Personally participate in the most demanding aspects of the anesthesia plan, including, induction and emergence;
  - ✓ Ensure that any procedures in the anesthesia plan that he or she does not perform are done by a qualified individual as defined in program operating instructions;
  - ✓ Monitor the course of anesthesia administration at frequent intervals;
  - ✓ Remain physically present and available for immediate diagnosis and treatment of emergencies; and
  - ✓ Provide indicated post-anesthesia care.

- In addition, the anesthesia provider may direct no more than four anesthesia services concurrently. The anesthesia provider may not perform any other services while directing these services, other than attending to medical emergencies and other limited services as allowed by Medicare policy.

- The anesthesia provider must document in the client's medical record that the medical direction requirements were met. Providers do not need to submit documentation with each claim to substantiate these requirements.

- Anesthesia time begins when the anesthesia provider starts to physically prepare the client for the induction of anesthesia in the operating room area or its equivalent. When there is a break in continuous anesthesia care, blocks of time may be summed as long as there is continuous monitoring of the client within the blocks of time. Examples of this include, but are not limited to: time a client spends in an anesthesia induction room or under the care of an operating room nurse during a surgical procedure. Anesthesia time ends when the anesthesia provider or surgeon is no longer in constant attendance (i.e. when the client can be safely placed under postoperative supervision).

- Do not bill CPT codes 01953 or 01996 with an anesthesia modifier or with the time in the "units" field. MAA has assigned flat fees for these codes.

- MAA allows the following two anesthesia codes published in the American Society of Anesthesiology (ASA) Relative Value Guide (RVG):

ASA Code	Description
01991	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider)
01992	Anesthesia for diagnostic or therapeutic nerve blocks and injections-patient in the prone position (when block or injection is performed by a different provider)

  Use these ASA codes only when a provider, other than the one performing the block or the injection, administers anesthesia.

- MAA does not adopt any other ASA RVG codes that are not included in the CPT book. Bill all other anesthesia codes according to the descriptions published in the CPT book. When there are differences in code descriptions between the CPT book and the ASA RVG, MAA follows CPT code descriptions.

- MAA does not reimburse providers for anesthesia services when these services are billed using the CPT surgery, radiology, and/or medicine codes with anesthesia modifiers. **Continue to use the appropriate anesthesia modifier with anesthesia CPT and ASA codes.**

***Exception*:** Anesthesia providers may bill CPT Pain Management/Other Services procedure codes that are not paid with base and time units. These services are reimbursed as a procedure using RBRVS methodology. Do not bill time in the unit field or use anesthesia modifiers.

- When billing anesthesia for surgical abortions (CPT code 01964), you must indicate in the *Comments* section of the claim form "voluntary or induced abortion."

- When billing the following procedures, use only the codes indicated below:

  - ✓ Vasectomies: 00921;
  - ✓ Hysterectomies: 00846, 00944, 01962-01963, 01969;
  - ✓ Sterilizations: 00851; and
  - ✓ Abortions: 01964.

- When multiple surgical procedures are performed during the same period of anesthesia, bill the surgical procedure with the greatest base value, along with the total time in whole minutes.

- When more than one anesthesia provider is present, MAA pays each provider 50% of the allowed amount. MAA limits reimbursement in this circumstance to 100% of the total allowed reimbursement for the service.

- Providers must report the number of actual anesthesia minutes (calculated to the next whole minute) in the appropriate field of the claim form. MAA calculates the base units.

Regional Anesthesia

- Bill MAA the appropriate procedure code (e.g. epidural CPT code 62319) with no time units and no anesthesia modifier. MAA determines payment by using the procedure's maximum allowable fee, not anesthesia base and time units.

- Local nerve block CPT code 64450 (other than digital and metacarpal) for subregional anatomic areas (such as the hand, wrist, ankle, foot and vagina) is included in the global surgical package and is not reimbursed separately.

Other

- Patient acuity does not affect payment levels. Qualifying circumstances (CPT codes 99100, 99116, 99135, and 99140) are considered bundled and are not paid separately.

- MAA follows Medicare's policy to not reimburse surgeons for anesthesia services. Claims for anesthesia services with modifier 47 will be denied. Under Medicare's payment policy, **separate reimbursement** for local, regional, or digital block or general anesthesia administered by the surgeon is not allowed. These services are considered included in the RBRVS payments for the procedure.

- When billing for anesthesia services using CPT **unlisted anesthesia code 01999**, **providers must attach documentation** (operative report) **to their claim** indicating what surgical procedure was performed that required the anesthesia in order to receive reimbursement. MAA will determine payment amount after review of the documentation.

Anesthesia for Maternity **[Refer to WAC 388-531-0300(9)]**

- MAA reimburses a maximum of 6 hours (360 minutes) of anesthesia for labor and delivery time (CPT codes 01960, 01961, 01967 and 01968) per delivery, including multiple births and/or cesarean section delivery.

  Exception: The following obstetrical anesthesia codes are not subject to the 6-hour (360 minute) limitation: CPT codes 01962, 01963, 01964 and 01969.

- When billing more than one time-limited anesthesia code, the total time may not exceed 6 hours (360 minutes).

- Bill the applicable CPT anesthesia code with applicable modifier and time. To determine time for obstetric epidural anesthesia during normal labor and delivery and C-sections, time begins with insertion and ends with removal for a maximum of 6 hours per delivery.

- CPT codes 01968 and 01969 are anesthesia add-on codes to be used for cesarean delivery and cesarean hysterectomy following anesthesia given for a planned vaginal delivery. An additional base of 3 is allowed for 01968 and an additional base of 5 is allowed for 01969, in conjunction with the base of 6 for 01967. The time involved with each portion of the procedure should be reported with the appropriate CPT code.

  For example: When a planned vaginal delivery (CPT code 01967) is started and results in a cesarean delivery (CPT code 01968), the above mentioned anesthesia codes are considered to be one procedure. If an anesthesiologist and a certified registered nurse assistant (CRNA) are both involved, they must both bill each procedure with the appropriate modifier. If a CRNA is not involved, the anesthesiologist must bill 100% for both procedure codes.

- Anesthesia time for sterilization is added to the time for the delivery when the two procedures are performed during the same operative session. If the sterilization and delivery are performed during different operative sessions, the time is calculated separately.

Anesthesia Payment Calculation for Services Paid with Base and Time Units

- MAA's current anesthesia conversion factor is $20.44.
- Anesthesia time is paid using **one minute per unit**.
- Total anesthesia reimbursement is calculated by adding the base value for the anesthesia procedure with the actual time. Bill time in **total minutes** only, rounded to the next whole minute. Do not bill the procedure's base units.

The following table illustrates how to calculate the anesthesia payment:

Payment Calculation	
A.	Multiply base units by 15.
B.	Add total minutes to value from step A.
C.	Divide anesthesia conversion factor by 15, to obtain the rate per minute.
D.	Multiply total from Step B by the rate per minute in Step C.

Anesthesia conversion factor is based on 15-minute time units.

Anesthesia for Dental

General anesthesia is allowed when provided by an anesthesiology provider for dental admissions. Providers must use CPT anesthesia **code 00170** with the appropriate anesthesia modifier to bill for dental anesthesia.

☞ **Note:** Bill MAA directly for dental anesthesia for all clients, including those enrolled in an MAA managed care plan.

Teaching Anesthesiologists

MAA reimburses teaching anesthesiologists for supervision of anesthesiology residents as follows:

- When supervising ***one*** resident only, the teaching anesthesiologist must bill MAA the appropriate anesthesia procedure code with **modifier AA**. Reimbursement to the teaching anesthesiologist will be 100% of the allowed amount.

- When supervising ***two or more*** residents concurrently the teaching anesthesiologist must bill MAA the appropriate anesthesia procedure codes with **modifier QK**. Reimbursement to the teaching anesthesiologist will be 50% of the allowed amount for each case supervised.

Pain Management Services

- Pain Management services and selected surgical services that are commonly performed by anesthesiologists and CRNAs are not paid with anesthesia base and time units. These services are paid using MAA's-assigned maximum allowable fee for the procedure code.

- Do not use anesthesia modifiers when billing for pain management and other services payable using MAA's-assigned maximum allowable fee. MAA denies claims for these services billed with an anesthesia modifier.

- Two postoperative procedures are allowed for pain management. Only one (1) unit may be billed per procedure. Do NOT bill time.

See next page for Pain Management Procedure Codes

Due to copyright restrictions, MAA publishes only official brief CPT descriptions
To view the full CPT description, please refer to your current CPT manual.

The listings shown below are not guaranteed to be all-inclusive, and are provided for convenience purposes only.

The codes listed in the following table with an asterisk (*) are limited to two (2) during the postoperative period while the client is admitted to the hospital. Do not bill modifier 59 with any of these procedure codes.

Procedure Code	Brief Description
11981*	Insert drug implant device
11982*	Remove drug implant device
11983*	Remove/insert drug implant
20526*	Ther injection, carpal tunnel
20550	Inject tendon/ligament/cyst
20551	Inject tendon origin/insert
20552	Inject trigger point, 1 or 2
20553	Inject trigger points, >3
20600	Drain/inject, joint/bursa
20605	Drain/inject, joint/bursa
20610	Drain/inject, joint/bursa
20612	Aspirate/inj ganglion cyst
27096	Inject sacroiliac joint
61790*	Treat trigeminal nerve
62264*	Epidural lysis on single day
62270	Spinal fluid tap, diagnostic
62272	Drain spinal fluid
62273*	Treat epidural spine lesion
62280*	Treat spinal cord lesion
62281*	Treat spinal cord lesion
62282*	Treat spinal canal lesion
62284	Injection for myelogram
62290	Inject for spine disk x-ray
62291	Inject for spine disk x-ray
62310*	Inject spine c/t
62311*	Inject spine l/s (cd)
62318*	Inject spine w/cath, c/t
62319*	Inject spine w/cath l/s (cd)
62350*	Implant spinal canal cath
62351*	Implant spinal canal cath
62355*	Remove spinal canal cath
62360*	Insert spine infusion device

Procedure Code	Brief Description
62361*	Implant spine infusion pump
62362*	Implant spine infusion pump
62365*	Remove spine infusion device
63650*	Implant neuroelectrodes
63655*	Implant neuroelectrodes
63660*	Revise/remove neuroelectrode
63685*	Implant neuroreceiver
63688*	Revise/remove neuroreceiver
64400*	Injection for nerve block
64402*	Injection for nerve block
64405*	Injection for nerve block
64408*	Injection for nerve block
64410*	Injection for nerve block
64412*	Injection for nerve block
64413*	Injection for nerve block
64415*	Injection for nerve block
64416*	Injection for nerve block
64417*	Injection for nerve block
64418*	Injection for nerve block
64420*	Injection for nerve block
64421*	Injection for nerve block
64425*	Injection for nerve block
64430*	Injection for nerve block
64435*	Injection for nerve block
64445*	Injection for nerve block
64446*	Injection for nerve block
64447*	Injection for nerve block
64448*	Injection for nerve block
64449*	Injection for nerve block
64450*	Injection for nerve block

Procedure Code	Brief Description
64470*	Inj paravertebral c/t
64472*	Inj paravertebral c/t add-on
64475*	Inj paravertebral l/s
64476*	Inj paravertebral l/s add-on
64479*	Inj foramen epidural add-on
64480*	Inj foramen epidural add-on
64483*	Inj foramen epidural l/s
64484*	Inj forament epidural add-on
64505*	Injection for nerve block
64508*	Injection for nerve block
64510*	Injection for nerve block
64517*	N block stellage ganglion
64520*	Injection for nerve block
64530*	Injection for nerve block
64550*	Apply neurostimulator
64553*	Implant neuroelectrodes
64555*	Implant neuroelectrodes
64560*	Implant neuroelectrodes
64561*	Implant neuroelectrodes
64565*	Implant neuroelectrodes
64573*	Implant neuroelectrodes
64575*	Implant neuroelectrodes
64577*	Implant neuroelectrodes
64580*	Implant neuroelectrodes
64581*	Implant neuroelectrodes
64585*	Revised/remove neuroelectrode
64590*	Implant neuroreceiver
64595*	Revise/remove neuroreceiver
64600*	Injection treatment of nerve
64605*	Injection treatment of nerve
64610*	Injection treatment of nerve
64612*	Destroy nerve, face muscle
64613*	Destroy nerve, spine muscle
64620*	Injection treatment of nerve
64622*	Destr paravertbrl nerve l/s
64626*	Destr paravertbrl nerve c/t
64627*	Destr paravertbrl nerve add-on

Procedure Code	Brief Description
64630*	Injection treatment of nerve
64640*	Injection treatment of nerve
64680*	Injection treatment of nerve
64681*	Injection treatment of nerve
64802*	Remove sympathetic nerves
64804*	Remove sympathetic nerves
64809*	Remove sympathetic nerves
64818*	Remove sympathetic nerves

Other Services

Procedure Code	Brief Description
36400	Drawing blood
36420	Establish access to vein
36425	Establish access to vein
36555	Insert non-tunnel cv cath
36566	Insert tunneled cv cath
36568	Insert tunneled cv cath
36580	Replace tunneled cv cath
36584	Replace tunneled cv cath
36589	Removal tunneled cv cath
36600	Withdrawal of arterial blood
36620	Insertion catheter, artery
36625	Insertion catheter, artery
36660	Insertion catheter, artery
62263	Lysis epidural adhesions
62287	Percutaneous diskectomy
63600	Remove spinal cord lesion
75998	Fluoroscope examination
76000	Fluoroscope examination
76003	Needle localization by x-ray
76005	Fluoroguide for spine inject
76496	Fluoroscopic procedure
93503	Insert/place heart catheter
95970	Analyze neurostim, no prog
95990	Spin/brain pump refil & main

These codes are paid as a procedure using MAA's maximum allowable fee, not with base units and time.

Major Trauma Services

Payment enhancements apply to nongovernmental Trauma Services. Physicians and clinical providers on the Trauma teams of governmental hospitals receive enhancements on a per patient basis. See page F.35 for a list of the Designated Trauma Services. Page F.36 lists the Department of Health's (DOH) categories of Physician and Clinical Providers for the Trauma Response Teams.

Payment Limitations for Major Trauma

To receive enhanced payment, DOH must identify the facility as a Designated Trauma Services. The facility's staff must maintain a quality improvement program and submit trauma registry data as prescribed by DOH. Verification of trauma service designation and patients' Injury Severity Score (ISS) is done by DOH.

Enhanced payments are limited to services provided by a member of a Designated Trauma Services Trauma Response Team for MAA clients who require major trauma services. Enhanced payments are limited to services performed in the hospital.

These enhancements are only for fee-for-service Medicaid clients and for hospital-based services.

Additional funds are available for treatment related to major trauma at Designated Trauma Services; however, **modifier ST must be entered on the claim form to receive the enhanced payment**.

☞ **Note:** The current Injury Severity Score (ISS) is 13 or greater for adults, and 9 or greater for pediatric clients (through 14 years of age only) and for transferred patients. Enhanced payment is available if the client meets these criteria.

Non-Designated Centers and Providers

Physicians and clinical providers not identified by DOH as Designated Trauma Services are reimbursed using MAA's maximum allowable fee schedule. A non-designated clinic that becomes designated during the course of the year must notify MAA at the address below of the change of status.

Medical Assistance Administration
Provider Enrollment Unit
PO Box 45562
Olympia, WA 98504-5562
(866) 545-0544

Billing

Bill MAA for qualified trauma services by adding modifier ST to the appropriate procedure code. If it is necessary to bill using two or more modifiers on a detail line and modifier 26 (professional component) is one of the modifiers:

- Bill modifier ST in the first modifier field; and
- Modifier 26 (professional component) in the second modifier field.

Bill all other multiple modifier combinations by using modifier 99 in the first modifier field, modifier ST in the second modifier field, and other applicable modifiers in the third and fourth modifier fields. Billing all modifiers with modifier 99, except the modifier ST/26 combination, ensures appropriate payment. Claims billed inappropriately must be rebilled on MAA's blue Adjustment Request Form [DSHS Form # 525-109].

For Additional Information

For information on **trauma service designation, trauma registry, and/or injury severity scores (ISS)**, contact:

Chris Williams
Department of Health
Office of Emergency Medical & Trauma Prevention
(360) 705-6735 or 1-800-725-1834.

For information on **reimbursement**, contact:

Larry Linn, Hospital Rates Unit Manager
Medical Assistance Administration
Hospital/Managed Care Rates Section
(360) 725-1834

For information on a specific **Medicaid trauma claim**, contact:

MAA's Provider Relations Unit
1-800-562-6188

DESIGNATED TRAUMA SERVICES

Level I

Name of Trauma Service	Notes
Central Washington (Wenatchee)	General
Good Samaritan (Puyallup)	General and Pediatric Rehabilitation
Harborview (Seattle)	General, Pediatric, and General Rehabilitation
Oregon Health Sciences (Portland)	Designated by Oregon only
Providence St. Peter (Olympia)	General Rehabilitation

Level II

Name of Trauma Service	Notes
Central Washington (Wenatchee)	Pediatric
Deaconess (Spokane)	General and Pediatric. Has joint agreement with Sacred Heart
Kadlec (Richland)	General Rehabilitation. Has joint agreement with Kennewick General and Lourdes
Kennewick General (Kennewick)	General Rehabilitation. Has joint agreement with Kadlec and Lourdes
Mary Bridge's (Tacoma)	Pediatric
Northwest (Seattle)	General Rehabilitation
Providence (Everett - Colby)	General Rehabilitation
Sacred Heart (Spokane)	Has joint agreement with Deaconess.
Southwest Wash. (Vancouver)	General and General Rehabilitation
St. Joseph (Bellingham)	
St. Joseph (Lewiston)	General
St. Mary Med. Ctr. (Walla Walla)	General Rehabilitation

Level III

Name of Trauma Service	Notes
Auburn Regional (Auburn)	
Good Samaritan (Puyallup)	General
Grays Harbor Community (Aberdeen)	
Harrison Memorial (Bremerton)	
Holy Family (Spokane)	
Island (Anacortes)	
Kadlec (Richland)	General Rehabilitation. Has joint agreement with Kennewick General and Lourdes

Name of Trauma Service	Notes
Kadlec (Richland)	Has joint agreement with Kennewick General and Lourdes
Kennewick General (Kennewick)	General. Has joint agreement with Kadlec and Lourdes.
Mary Bridge's (Tacoma)	Pediatric
Olympia Medical Center (Pt. Angeles)	
Our Lady of Lourdes (Pasco)	
Overlake (Bellevue)	
Providence (Everett - Colby)	General
Providence St. Peter (Olympia)	General
Pullman Memorial (Pullman)	
Skagit Valley (Mt. Vernon)	
St. Johns (Longivew)	
St. Joseph (Lewiston)	Pediatric
St. Mary Med. Ctr. (Walla Walla)	General and Pediatric
Valley (Spokane)	
Valley Med. Ctr. (Renton)	General and General Rehabilitation
Walla Walla General (Walla Walla)	
Whidbey General (Coupeville)	
Yakima Valley/Prov Yak Med (Yakima)	General and Pediatric. Has joint agreement with Yakima Regional Medical Center.

Level IV

Name of Trauma Service	Notes
Cascade Valley (Arlington)	
Coulee Community (Grand Coulee)	
Deer Park (Deer Park)	
Evergreen Hospital (Kirkland)	
Forks Community (Forks)	
Highline Community (Burien)	
Kittitas Valley (Ellendsburg)	
Klickitat Valley (Goldendale)	
Lake Chelan Community (Chelan)	
Lincoln (Davenport)	
Mason General (Shelton)	
Mid Valley (Omak)	
Morton General Hospital (Morton)	
Mt. Carmel (Colville)	
Newport Comm. Hospital (Newport)	
North Valley (Tonasket)	
Northwest (Seattle)	General

Name of Trauma Service	Notes
Ocean Beach (Ilwaco)	
Okanogan-Douglas (Brewster)	
Prosser Memorial (Prosser)	
Providence (Centralia)	
Samaritan (Moses Lake)	
Skyline (White Salmon)	
St. Francis (Federal Way)	
St. Joseph (Chewelah)	
Stevens Memorial (Edmonds)	
Sunnyside Community (Sunnyside)	
Toppenish Community Hospital (Toppenish)	
Tri-State Memorial (Clarkston)	
Valley General (Monroe)	
Willapa Harbor Hosp. (South Bend)	

Level V

Name of Trauma Service	Notes
Cascade Medical (Leavenworth)	
Columbia Basin (Ephrata	
Darrington (Darrington)	
Dayton General (Dayton)	
East Adams Rural (Ritzville)	
Ferry Co. Memorial (Republic)	
Garfield County (Pomeroy)	
Inter-Island (Friday Harbor)	
Mark Reed (McCleary)	
Odessa Memorial (Odessa)	
Othello Community (Othello)	
Quincy Valley (Quincy)	
Whitman County (Colfax)	

PHYSICIAN/CLINICAL PROVIDER LIST

Advanced Registered Nurse Practitioner
Anesthesiologist
Cardiologist
Certified Registered Nurse Anesthetist
Critical Care Physician
Emergency Physician
Family/General Practice Physician with
Gastroenterologist
General Surgeon
Gynecologist
Hand Surgeon
Hematologist
Infectious Disease Specialist
Internal Medicine
Nephrologist
Neurologist
Neurosurgeon
Obstetrician
Ophthalmologist
Oral/Maxillofacial Surgeon
Orthopedic Surgeon
Pediatric Surgeon
Pediatrician
Physiatrist
Physician Assistant
Plastic Surgeon
Pulmonologist
Radiologist
Thoracic Surgeon
Trauma Training
Urologist
Vascular Surgeon

☞ **Note:** Many procedures are not included in major trauma services enhanced payment.

Coverage [WAC 388-545-500(4)]

MAA reimburses providers for only those covered physical therapy services listed in this section when they are:

- Within the scope of an eligible client's medical care program;
- Medically necessary and ordered by a physician, PA, or an ARNP;
- Begun within 30 days of the date ordered;
- For conditions which are the result of injuries and/or medically recognized diseases and defects; and
- Within accepted physical therapy standards.

> ☞ **Note**: MAA does not limit covered physical therapy services for clients 20 years of age and younger.

Coverage for adults (age 21 and older) [Refer to WAC 388-545-500 (8)]

MAA covers without prior authorization the following physical therapy services per client, per diagnosis:

- One physical therapy evaluation (in addition to the 48 program unit limitation below) per calendar year;
- 48 physical therapy program units per calendar year;
- One visit to instruct the client in the application of transcutaneous electrical neurostimulator (TENS) per lifetime.
- Two DME needs assessments per calendar year (in addition to the 48 program units). Two 15-minute units are allowed per DME needs assessment;
- One wheelchair needs assessment per calendar year (in addition to the two DME needs assessment). Four 15-minute units are allowed per wheelchair assessment).

MAA covers up to 96 physical therapy program units per calendar year *in addition* to the original 48 units only when:

- The client is diagnosed with one of the following conditions:

ICD-9-CM Diagnosis Codes	Condition
315.31-315.9, 317-319	Medically necessary conditions for individuals identified as having developmental disabilities
343.0 - 343.9	Cerebral palsy
741.90-741.93	Meningomyelocele
758.0	Down syndrome
781.2 - 781.3	Symptoms involving nervous and musculoskeletal systems, lack of coordination
800.00 - 829.1	Surgeries involving extremities – Fractures
851.00 - 854.19	Intracranial injuries
880.00 - 887.7	Surgeries involving extremities - Open wounds with tendon involvement
941.00 - 949.5	Burns
950.0 - 957.9, 959.01 - 959.9	Traumatic injuries

☞ **Note**: The conditions above **must** be listed as the primary diagnosis on the claim.

-OR-

- The client no longer needs nursing services, but continues to require specialized outpatient physical therapy as part of a recently approved Acute PM&R program (within the previous 12 months) for the following conditions:

ICD-9-CM Diagnosis Codes	Condition
854.00-854.19	Traumatic brain injury
900.82, 344.00- 344.09, 344.1	Spinal cord injury (paraplegia and/or quadriplegia)
436	Recent or recurrent stroke
340	Restoration of the levels of function due to secondary illness or loss for multiple sclerosis
335.20	Amyotrophic lateral sclerosis
343.0 – 343.9	Cerebral palsy
357.0	Acute infective polyneuritis (Guillain-Barre' syndrome)

(continued on next page…)

(Continued from previous page…)

ICD-9-CM Diagnosis Codes	Condition
941.40-941.49, 941.50-941.59, 942.40-942.49, 942.50-942.59, 943.40-943.49, 943.50-943.59, 944.40-944.48, 944.50-944.58, 945.40-945.49, 945.50-945.59, 946.4, 946.5	Extensive severe burns
344.00-344.09, 707.00-707.09	Skin flaps for sacral decubitus for quads only
890.0 - 897.7, 887.6 - 887.7	Open wound of lower limb, bilateral limb loss

Physical Therapy Program Limitations

MAA does not cover duplicate services for occupational and physical therapy for the same client when both providers are performing the same or similar procedure(s).
[WAC 338-545-500 (11)]

☞ **Note**: A program unit is based on the CPT code description. For CPT codes that are timed, each 15 minutes equals one unit. If the description does not include time, the procedure equals one unit regardless of how long the procedure takes. If time is included in the CPT description, the beginning and ending times of each therapy modality must be documented in the client's medical record.

The following are considered part of the physical therapy program 48-unit limitation:

- Application of a modality to one or more areas not requiring direct patient contact (CPT codes 97010-97028).
- Application of a modality to one or more areas requiring direct patient contact (CPT codes 97032-97039).
- Therapeutic exercises (CPT codes 97110-97139).
- Manual therapy (CPT code 97140).
- Therapeutic procedures (CPT code 97150).
- Prosthetic training (CPT code 97520).

- Therapeutic activities (CPT code 97530).

- Self-care/home management training (CPT code 97535).

- Community/work reintegration training (CPT code 97537).

- Physical performance test or measurement (CPT code 97750). Do not use to bill for an evaluation (CPT code 97001) or re-evaluation (CPT code 97002).

- Assistive technology assessment (CPT code 97755).

The following are not included in the physical therapy program 48-unit limitation:

- Muscle testing (CPT codes 95831-95852). MAA covers one muscle testing procedure per day. Muscle testing procedures cannot be billed in combination with each other. These procedures can be billed alone or with other physical therapy CPT codes.

- Physical therapy evaluation (CPT code 97001). Use for reporting the initial evaluation before the plan of care is established by the physical therapist or the physician. This procedure is not used for re-evaluating the client's condition and establishing the plan of care.

- Physical therapy re-evaluation (CPT code 97002). Allowed once per client, per calendar year. Use for reporting the re-evaluation of a client who has been under a plan of care established by a physician or physical therapist. This procedure is for re-evaluating the client's condition and revising the plan of care under which the client is being treated.

- Orthotics fitting and training upper and/or lower extremities (CPT code 97504). MAA covers two units per day. This procedure can be billed alone or with other physical therapy CPT codes.

- Active wound care management involving selective and non-selective debridement (CPT codes 97601 and 97602). The following conditions apply:

  - ✓ MAA covers one unit of CPT code 97601 or 97602 per client, per day. Providers may not bill CPT codes 97601 and 97602 in conjunction with each other.

  - ✓ Providers must not bill CPT codes 97601 and 97602 in addition to CPT codes 11040-11044.

- Checkout for orthotic/prosthetic use (CPT code 97703). MAA covers two 15-minute units per day. This procedure can be billed alone or with other physical therapy CPT codes.

- Wheelchair needs assessment (CPT code 97703). MAA covers one wheelchair needs assessment per client, per calendar year, limited to four 15-minute units per assessment. Indicate on the claim that this is a wheelchair needs assessment.

- DME needs assessments (CPT code 97703). MAA covers two DME needs assessments per client, per calendar year, limited to two 15-minute units per assessment. Indicate on the claim that this is a DME needs assessment.

- Splints (refer to Section K for those splints covered in a provider's office).

How do I request approval to exceed the limits?

For clients 21 years of age and older who need physical therapy in addition to existing program unit limitations, the provider must request a Limitation Extension (LE). See Section I – Prior Authorization.

Are school medical services covered?

MAA covers physical therapy services provided in a school setting for school-contracted services that are noted in the client's Individual Education Program (IEP) or Individualized Family Service Plan (IFSP). Refer to MAA's *School Medical Services Billing Instructions*. (See Important Contacts.)

What is not covered? [WAC 388-545-500(12)]

MAA does not reimburse separately for physical therapy services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

Miscellaneous Services

Acute Physical Medicine and Rehabilitation (Acute PM&R): Inpatient PM&R is limited to MAA-contracted facilities.

DDD Physical: MAA covers one physical every 12 months for clients with disabilities. Use HCPCS code T1023 with modifier HI and an ICD-9-CM diagnosis code from the range V79.3-V79.9 to bill for an annual exam.

HIV/AIDS Counseling: MAA covers two sessions of risk factor reduction counseling (CPT code 99401) for HIV/AIDS counseling per client, per lifetime. **[Refer to WAC 388-531-0600]** Use ICD-9-CM diagnosis code V65.44 when billing CPT code 99401 for HIV/AIDS counseling.

Needle Electromyography (EMGs): MAA has adopted Medicare-established limits for billing needle EMGs (CPT codes 95860 – 95870) as follows:

CPT Code	Brief Description	Limits
95860 95861 95863 95864	Needle EMG; one extremity with or without related paraspinal areas two extremities… three extremities… four extremities…	• Extremity muscles innervated by three nerves or four spinal levels must be evaluated with a minimum of five muscles studied.
95869	Needle EMG; thoracic paraspinal muscles	• Limited to one unit per day. • For this to pay with extremity codes 95860-95864, test must be for T3-T11 areas only; T1 or T2 alone are not separately payable.
95870	Needle EMG; other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters	• Limited to one unit **per extremity**, and one unit for cervical or lumbar paraspinal muscle, regardless of number of levels tested (maximum of 5 units). • Not payable with extremity codes (CPT codes 95860-95864).

TB Treatment Services: The E&M codes 99201-99215 are for office visits only, and must be billed for professional providers such as physicians (or nursing staff under a physician's supervision), Advanced Registered Nurse Practitioners (ARNPs), and Physician Assistants (PAs).

When billing for TB treatment services provided by professional providers in the client's home, Health Departments may also bill CPT codes 99341 and 99347.

Procedure Code	Brief Description
99341	Home visit, new patient
99347	Home visit, est patient

TB Treatment Services Performed by Non-Professional Providers: Health Departments billing for TB treatment services provided by **non-professional providers** in either the client's home or in the office must bill using HCPCS code T1020 (personal care services). Do not bill the initial visit with a modifier. Follow-up visits must be billed using T1020 with modifier TS (follow-up services modifier).

☞ **Note:** Continue to bill using the appropriate TB-related diagnosis code.

Collagen Implants

MAA reimburses for CPT code 51715 and HCPCS code L8603 only when the diagnosis code is 599.82 (Intrinsic sphincter deficiency).

Ventilator Management

CPT codes 94656, 94657, 94660, and 94662 for Ventilator Management are not billable with Evaluation and Management (E&M) services.

Cochlear Implant Services [Refer to WAC 388-531-0200(4) (c)]

- Cochlear implantation (CPT code 69930) requires prior authorization (refer to Section I – Prior Authorization). Providers must send in medical documentation to justify the need for cochlear implants. In particular, MAA requires information on how the client was counseled on the different options for dealing with hearing loss such as, but not limited to, manual language.

- MAA reimburses providers for replacement parts for cochlear implants given directly to the client using HCPCS codes L8615-L8618.

- When reimbursing for battery packs, MAA covers the **least costly, equally effective** product.

> ☞ **Note:** MAA does not reimburse providers for repairs or replacements that are covered under the manufacturer's warranty.

Vagus Nerve Stimulation (VNS) [Refer to WAC 388-531-0200(h)]

- Vagus nerve stimulation (CPT codes 61885, 61886, 64573, and 64585) requires prior authorization (refer to Section I - Prior Authorization).
- VNS procedures can be performed in an inpatient hospital or outpatient hospital setting.
- Prior authorization is not required for VNS programming (CPT codes 95970, 95974, and 95975) performed by a neurologist.

Osseointegrated Implants

- Insertion of osseointegrated implants (CPT codes 69714-69718) requires prior authorization (refer to Section I - Prior Authorization).
- The procedure can be performed in an inpatient hospital setting or outpatient hospital setting.
- Limitations on coverage for certain miscellaneous procedures are listed below:

Procedure Code	Brief Description	Limitation Restricted to ICD-9-CM
11980	Implant hormone pellet(s)	257.2 and 174-174.9
S0139	Minoxidil, 10 mg	401-401.9 (essential hypertension)
S0189	Testosterone pellet 75 mg	257.2, 174.0-174.9 and only when used with CPT code 11980

Family Planning

What is Family Planning? [WAC 388-532-050]

Family planning is medical care, contraceptive supplies, and educational services that enable individuals to plan and space the number of children by using contraception to avoid unintended pregnancy.

Contraceptive Management

The following contraceptives may be administered in a provider's office:

Procedure Code	Brief Description
Cervical Cap/Diaphragm	
A4261	Cervical cap for contraceptive use
A4266	Diaphragm
57170	Fitting of diaphragm/cap
Implant	
11976	Removal of contraceptive capsule
Injectables	
J1055	Medroxyprogesterone acetate inj (Depo Provera). (Allowed once every 67 days.)
90782	Injection, subcutaneous/intramuscular. (Allowed when the contraceptive injection is the only service performed.)
Intrauterine Devices (IUD)	
J7300	Intrauterine copper device (Paragard)
J7302	Levonorgestrel-releasing IUD (Mirena)
58300	Insertion of IUD
58301	Removal of IUD
J3490*	Unclassified Drugs Use for emergency contraceptive pills, including Preven and Plan B.

***Claims billed with unlisted drug code J3490 must include the NDC and the dose administered to the client in field 19 of the hard copy HCFA-1500 claim form or the *Comments* section of the electronic HCFA-1500 claim form. If the client is FP only or TAKE CHARGE J3490 also requires and EPA number.**

Sterilization

What is sterilization? [Refer to WAC 388-531-1550(1)]

Sterilization is any medical procedure, treatment, or operation for the purpose of rendering a client permanently incapable of reproducing. This includes vasectomies and tubal ligations.

> ☞ **Note:** MAA does not reimburse for hysterectomies performed solely for the purpose of sterilization. Refer to page H.16 for information on hysterectomies.

What are MAA's reimbursement requirements for sterilizations? [Refer to WAC 388-531-1550(2)]

MAA covers sterilization when all of the following apply:

- The client is at least 18 years of age at the time consent is signed;
- The client is a mentally competent individual;
- The client has **voluntarily** given informed consent in accordance with all of the requirements explained under this section as required by 42 CFR 441.258; and
- At least 30 days, but not more than 180 days, have passed between the date the client gave informed consent and the date of the sterilization.

> ☞ **Note:** MAA reimburses providers for sterilizations for managed care clients 18 through 20 years of age under the fee-for-service system.

MAA reimburses providers (e.g., hospitals, anesthesiologists, surgeons, and other attending providers) for the sterilization procedure only when a completed, federally approved Sterilization Consent Form is attached to the claim. MAA reimburses after the procedure is completed.

MAA reimburses providers for epidural anesthesia in excess of the six-hour limit for deliveries if sterilization procedures are performed in conjunction with, or immediately following, a delivery. MAA determines total billable units by:

- Adding the time for the sterilization procedure to the time for the delivery; and
- Determining the total billable units by adding together the delivery base anesthesia units (BAUs), the delivery time, and the sterilization time.

Do not bill the BAUs for the sterilization procedure separately.

Prior Authorization

[Refer to WAC 388-531-0200]

The prior authorization process only applies to covered services; and is subject to client eligibility and program limitations. Not all categories of eligibility receive all services. **For example:** Therapies are not covered under the Family Planning Only Program. Prior authorization does not guarantee payment.

MAA's prior authorization requirements are met through the following authorization processes:

- Limitation extensions (LE);
- Written or fax prior authorization (PA); and
- Expedited prior authorization (EPA).

These authorization procedures do not apply to out-of-state care. Out-of-state hospital admissions are not covered unless they are emergency admissions of clients who are on an eligible program that allows out-of-state care. **[Refer to WAC 388-502-0120]**

Limitation Extensions (LE)

What is an LE?

LE is an authorization process for medically necessary units of service that exceed the benefit or program allowance. The provider must verify medical necessity for the additional units of service. The medical record documentation must support the medical necessity and be available to MAA upon request. The allowed units of service are published in MAA's billing instructions and Washington Administrative Code (WAC).

How do I get LE authorization?

LE authorizations are obtained by using the EPA process. Refer to the EPA section (page I.5) for criteria. If the EPA process is not applicable, limitation extensions may be obtained using the written/fax prior authorization process (see below).

Written/Fax Prior Authorization

What is written/fax PA?

Written/fax prior authorization is an authorization process available to providers when expedited prior authorization criteria has not been established.

Which services require written/fax PA?

Services requiring written/fax PA are noted in WAC, MAA's billing instructions, and/or the fee schedule.

EXAMPLES of services that require written/fax PA include, but are not limited to:

Code(s)	Procedure
54416-54417	Repair of Penile Implant
55873	Cryosurgical Ablation of the Prostate
61885, 61886, 64573 and 64585	Vagus Nerve Stimulator Insertion, Removal, or Revision
66930	Cochlear Implantation
67909	Reduction of Overcorrection of Ptosis
69714-69718	Osseointegrated Implants
G0330 and G0331	Tumor imaging (PET)
88380	Microdissection
95965-95967	Magnetoencephalography (MEG)
99221-99223	Inpatient Acute PM&R
J2020	Linezolid injection
J2940	Somatrem injection
J2941	Somatropin injection
J7340	Metobolic active D/E tissue
S0093	Morphine 500 mg
0010T	New technology CPT Category III codes

How do I obtain written/fax PA?

Send a completed "Fax/Written Request Basic Information" form [DSHS # 13-756] to:

MAA – Division of Medical Management
Attn: Provider Request/Client Notification Unit
PO Box 45506
Olympia, WA 98504-5506
FAX: (360) 586-1471

How do I obtain authorization for PET scans?

Send a completed "PET Scan Information" form [DSHS # 13-757] to:

MAA – Division of Medical Management
Attn: Provider Request/Client Notification Unit
PO Box 45506
Olympia, WA 98504-5506
FAX: (360) 586-1471

Expedited Prior Authorization (EPA)

Expedited prior authorization does not apply to out-of-state care. Out-of-state hospital admissions are not covered unless they are emergency admissions of clients who are on an eligible program that allows out-of-state care.

- MAA's intent for the EPA process is to establish prior authorization criteria and identify these criteria with specific codes, enabling providers to create an "EPA" number when appropriate. MAA denies claims submitted without the appropriate EPA number related to the specific service. MAA also denies claims submitted without a required EPA number, when available.

How is an EPA number created and billed?

To bill MAA for a service that meets the EPA criteria on the following pages, the provider must **create a 9-digit EPA number.** The first six digits of the EPA number must be **870000**. The last 3 digits of the EPA number must be related to the client-specific service. Enter the entire 9-digit EPA number on the billing form in the authorization number field, or in the *Authorization* or *Comments* section when billing electronically.

Example: The 9-digit authorization number for a brain MRI in a client with suspected brain tumor and new onset of unexplained seizures would be **870000303** (**870000** = first six digits of all EPA numbers, **303** = last three digits of an EPA number indicating that the specific criteria is met).

☞ **Note:** Written/fax PA is required when there is no option to create an EPA number.

Expedited Prior Authorization Guidelines

Documentation

The provider must verify medical necessity for the EPA number submitted. The client's medical record documentation must support the medical necessity and be available upon MAA's request. If MAA determines the documentation does not support the EPA criteria being met, the claim will be denied**.**

Which services require EPA?

EPA is required for services noted in WAC, MAA's billing instructions, and/or fee schedules as needing EPA.

Examples of services requiring EPA:

- **Hysterectomies** (CPT: 51925, 58150-58285, 58545, 58546, 58550, 59525)
  Note: CPT codes 58152 and 58267 must meet guidelines for both hysterectomies and bladder repair.

  Exceptions: MAA does not require EPA for clients 46 years of age and older; **or** clients that have been diagnosed with cancer(s) of the female reproductive organs (ICD-9-CM: 179-184.9, 198.6, 198.82, 233.1-233.3, 236.0-236.3, and 239.5).

- **Bladder Repairs** (CPT: 51840-51845, 57288-57289, 58152, and 58267)
  Note: Bladder repairs are only allowed for clients with a diagnosis of stress urinary incontinence (ICD-9-CM: 625.6, 788.30-788.39)

- **Reduction Mammoplasties** (CPT: 19318)
  Note: Reduction Mammoplasties are only allowed with ICD-9-CM diagnosis codes 611.1 and 611.9.

- **Mastectomies for Gynecomastia** (CPT: 19140)
  Note: Mastectomies for Gynecomastia are only allowed with ICD-9-CM diagnosis codes 611.1 and 611.9.

- **Visual Exams, Dispensing and Fitting Fees, Frames, Glasses, and Lenses**
  When in excess of MAA's established limitations.

- **Blepharoplasties** (CPT: 15822, 15823, 67901-67908)

- **Strabismus Surgery** (CPT: 67311-67340) only for clients 18 years of age and older.

- **Physical and Occupational Therapy**
  When in excess of MAA's established limitations.

- **Outpatient PET Scans**
  Exception: HCPCS codes G0330 and G0331 require written/fax prior authorization.

- **Outpatient MRIs and MRAs**

- **Orthotics. Exception:** HCPCS codes L3170, L3230, L3340, L3350, L3360, L3400, L3410, L3420, L4360, L4386, and L5507 require written/ fax prior authorization.

- **Inpatient Medical Admissions** (CPT: 99221-99223)
  MAA requires EPA:

  ✓ For clients seven years of age and older; and
  ✓ When both the admitting and discharge (final/principle) diagnoses are on the list below:

Description	ICD-9-CM Diagnosis Code(s)
Abdominal Pain	789.00-789.09
Back Pain	724.00-724.6, 724.8-724.9, 846.0-847.9
Cellulitis	681.00-681.9, 682.0, 682.2-682.9
Chronic pancreatitis	577.1
Constipation	560.30, 560.39, 564.00-564.9
Dehydration; Disorders of Electrolyte Imbalance	276.0-276.6, 276.8-276.9
Gastritis/Gastroenteritis	535.00-535.61, 558.1-558.9
Headache	784.0
Malaise & Fatigue	780.71-780.79
Migraine Headache	346.00-346.91
Nausea/vomiting	536.2; 787.01-787.03
Painful Respiration	786.52
Related general symptoms	780.01, 780.4, and 780.91-780.99
Respiratory abnormality	786.09

  An outpatient/observation admission does not require prior authorization – use CPT codes 99218-99220 for an outpatient/observation admission and 99217 for an outpatient/observation discharge; or 99234-99236 for an outpatient/observation admission/discharge on the same calendar date.

MAA does not require EPA for inpatient medical admissions for clients six years of age and younger. However, these admissions must be medically appropriate in accordance with MAA's established criteria.

Washington State
Expedited Prior Authorization Criteria Coding List

Code	Criteria
Abdominal Hysterectomy	
CPT: 58150, 58180, 58200, 58210	
101	Diagnosis of ***abnormal uterine bleeding*** in a client 30 years of age or older with *two or more* of the following conditions: 1) Profuse uterine bleeding requiring extra protection more than eight days a month for more than 3 months; 2) Documented hct of <30 or hgb <10; or 3) Documented failure of conservative care (i.e., d&c, laparoscopy, or hormone therapy for at least three months).
102	Diagnosis of ***fibroids*** for any *one* of the following indications in a client 30 years of age or older: 1) Myomata associated with uterus greater than 12 weeks or 10cm in size; 2) Symptomatic uterine leiomyoma regardless of size with profuse bleeding more than eight days a month for three months requiring extra protection or documented hct <30 or hgb <10; or 3) Documented rapid growth in size of uterus/myomata by consecutive ultrasounds or exams.
103	Diagnosis of ***symptomatic endometriosis*** in a client 30 years of age or older with the following: 1) Significant findings per laproscope; *and* 2) Unresponsiveness to 3 months of hormone therapy or cauterization.
104	Diagnosis of ***chronic advanced pelvic inflammatory disease*** in a client 30 years of age or older with infection refractory to multiple trials of antibiotics

Code	Criteria
Vaginal Hysterectomy	
CPT: 58270-58285, 58550-58554, 58260-58263, 58290, 58291-58292, and 58294	
111	Diagnosis of ***abnormal uterine bleeding*** in a client 30 years of age or older with *two or more* of the following conditions: 1) Profuse uterine bleeding requiring extra protection more than eight days a month for more than 3 months; 2) Documented hct of < 30 or hgb < 10; or 3) Documentation of failure of conservative care (i.e., d&c, laparoscopy, or hormone therapy for at least three months).
112	Diagnosis of ***fibroids*** for any *one* of the following indications in a client 30 years of age or older: 1) Myomata associated with uterus greater than 12 weeks or 10cm in size; 2) Symptomatic uterine leiomyoma regardless of size with profuse bleeding more than eight days a month for three months requiring extra protection or documented hct < 30 or hgb < 10; or 3) Documented rapid growth in size of uterus/myomata by consecutive ultrasounds or exams.
113	Diagnosis of ***symptomatic endometriosis*** in a client 30 years of age or older with the following: 1) Significant findings per laproscope; *and* 2) Unresponsiveness to 3 months of hormone therapy or cauterization.
114	Diagnosis of ***chronic advanced pelvic inflammatory disease*** in a client 30 years of age or older with infection refractory to multiple trials of antibiotics.

Code	Criteria

115 Diagnosis of ***symptomatic pelvic relaxation*** (in a client 30 years of age or older) with a 3rd degree or greater uterine prolapse (at or to vaginal introitus).

Bladder Neck Suspension

CPT: 51840-51845, 57288-57289

201 Diagnosis of ***stress urinary incontinence*** with all of the following:

1) Documented urinary leakage severe enough to cause the client to be pad dependent; *and*
2) Surgically sterile or past child bearing years; *and*
3) Failed conservative treatment with one of the following: bladder training or pharmacologic therapy; *and*
4) Urodynamics showing loss of ureterovescical angle or physical exam showing weak bladder neck; *and*
5) Recent gynecological exam for coexistent gynecological problems correctable at time of bladder neck surgery.

Hysterectomy with Colopourethrocystopexy

CPT: 51925, 58152, 58267, and 58293

221 Diagnosis of ***Abnormal uterine bleeding and Stress Urinary Incontinence***-meeting criteria 101 or 111 and 201.

222 Diagnosis of ***Fibroids and Stress Urinary Incontinence***-meeting criteria 102 or 112 and 201.

223 Diagnosis of ***Symptomatic Endometriosis and Stress Urinary Incontinence***-meeting criteria 103 or 113 and 201.

224 Diagnosis of ***Chronic Pelvic Inflammatory Disease and Stress Urinary*** **Incontinence -** meeting criteria 104 and 114.

225 Diagnosis of ***Symptomatic Pelvic Relaxation and Stress Urinary*** **Incontinence -** meeting criteria 115 and 201.

226 ***Hysterectomy not requiring authorization*** and ***Stress Urinary Incontinence*** meeting criteria 201.

Other Hysterectomies and/or Bladder Repairs with Diagnosis of 625.6 or 788.30-788.39

CPT: 51840-51845, 51925, 57288-57289, 58150, 58152, 58180, 58200, 58210, 58240, 58260-58263, 58267, 58270, 58275, 58280, 58285, 58290-58294. 58550-58554, and 59525

230 Hysterectomies and/or bladder repairs not meeting expedited criteria, but medically necessary/medically appropriate in accordance with established criteria. Evidence of medical appropriateness must be clearly evidenced by the information in the client's medical record.

Reduction Mammoplasties/ Mastectomy for Gynecomastia

CPT: 19318, 19140
DX: 611.1 and 611.9 only

241 Diagnosis for ***hypertrophy of the breast*** with:

1) Photographs in client's chart, *and*
2) Documented medical necessity including:
   a) Back, neck, and/or shoulder pain for a minimum of one year, directly attributable to macromastia, *and*
   b) Conservative treatment not effective; *and*
3) Abnormally large breasts in relation to body size with shoulder grooves, *and*
4) Within 20% of ideal body weight, *and*
5) Verification of minimum removal of 500 grams of tissue from each breast.

242 Diagnosis for **gynecomastia**:

1) Pictures in clients' chart, *and*
2) Persistent tenderness and pain, *and*
3) If history of drug or alcohol abuse, must have abstained from drug or alcohol use for no less than one year.

Code	Criteria

Other Reduction Mammoplasties/ Mastectomy for Gynecomastia With Diagnosis of 611.1 Or 611.9

250 Reduction mammoplasty or mastectomy, not meeting expedited criteria, but medically necessary/medically appropriate in accordance with established criteria. Evidence of medical appropriateness must be clearly evidenced by the information in the client's medical record.

Brain MRI/MRA

CPT: 70544-70546, 70551-70559

301 Suspected diagnosis of ***acoustic neuroma*** if one of the following:

1) Unilateral sensorineural hearing loss per audiogram; *or*
2) Decreased discrimination score that is out of proportion to amount of hearing loss per ENT evaluation; or
3) Positive or inconclusive computed tomography with a need for clearer definition, and one of the above.

302 Suspected diagnosis of ***pituitary tumor*** with any *two* of the following:

1) Galactorrhea;
2) Pre menopausal amenorrhea;
3) Elevated prolactin level **(females must have negative pregnancy test)**; or
4) Positive or inconclusive computed tomography and one of the above with a need for clearer definition

303 Suspected diagnosis of ***brain tumor*** with any one of the following:

1) Unexplained new onset seizure;
2) Objective evidence of increased intracranial pressure; or
3) Positive or inconclusive computed tomography with a need for clearer definition, and *one* of the above.

304 ***Follow up*** of ***brain tumor*** if done at:

1) Three months from the date of last MRI/MRA and in the first two years of diagnosis in any of the following cases:
   a) Tumor is currently being treated;
   b) Post treatment;
   c) With documented changes in tumor size; *or*
2) Six months from the date of last MRI/MRA and in the second to fifth years of diagnosis; *or*
3) One year from the date of last MRI/MRA in the sixth to tenth year of diagnosis; *or*
4) Symptoms of recurrence in a client that would be treated aggressively.

305 Suspected diagnosis of ***multiple sclerosis*** with *three or more* of the following objective findings:

1) Progressive weakness or decreased sensation in extremities;
2) Difficulty word finding;
3) Diplopia;
4) Vertigo or vertigo nystagmus;
5) Optic neuritis;
6) Facial weakness; or
7) Positive Lhermitte's sign.

Note to 305: Only for initial diagnosis, not as a follow-up.

306 Suspected diagnosis of ***toxoplasmosis versus lymphoma versus progressive multifocal leukoencephalopathy*** in an HIV positive client with:

1) Central nervous system changes **in a client that would be aggressively treated**; and
2) Positive or inconclusive computed tomography with a need for clearer definition **in a client that would be aggressively treated.**

307 Diagnosis of ***breast cancer*** for staging as part of PSCT or BMT protocol.

Code	Criteria

308 Suspected diagnosis of ***seizure disorder*** with unexplained onset of seizures.

309 Diagnostic evidence of ***refractory seizures***, as part of preoperative work up.

310 Suspected diagnosis of ***residual tumor or residual vascular malformation***

Lumbar MRI/MRA

CPT: 72148, 72149, 72158

311 Suspected diagnosis of ***Herniated Nucleus Pulposus or Tumor*** in a surgical candidate with two or more of the following objective findings:

1) New onset of bowel or bladder incontinence not related to known diagnosis;
2) Asymetric or bilaterally absent tendon reflexes in the lower extremity (patella/achilles);
3) Visible atrophy of key muscle groups of lower extremities;
4) Decreased sensation in a dermatomal pattern not previously attributed to another diagnosis;
5) Significant weakness of key muscle groups of either or both lower extremity; or
6) Positive study indicating definitive nerve root compression.

312 Suspected diagnosis of ***tumor or abscess*** with a bone scan or x-ray suspicious for same.

Cervical MRI/MRA

CPT: 72141, 72142, 72156

321 Suspected ***herniated nucleus pulposa or tumor*** with *two or more* of the following objective findings:

1) Decreased tricep, bicep, or brachial radialis reflex;
2) Decreased sensation in upper extremities in a dermatomal distribution;
3) Decreased muscle strength of upper extremities and limitation of movement;
4) Upper extremity muscle atrophy;
5) Hyperreflexia;
6) Positive babinski in non-infant; or
7) Studies showing definitive nerve root compression, and ruling out carpal tunnel syndrome.

Note to 321: Carpal tunnel syndrome must be ruled out prior to cervical MRI when symptoms indicate possible carpal tunnel syndrome.

322 Suspected diagnosis of ***tumor or abscess*** with a bone scan or x-ray suspicious for same.

Thoracic MRI/MRA

CPT: 72146, 72147, 72157

331 Suspected diagnosis of ***tumor or abscess***:

1) With a bone scan or x-ray suspicious for same, *or*
2) Evidence of myelopathy, such as hyperreflexia, positive babinski in a non-infant, ataxia, etc.

Pelvic MRI/MRA

CPT: 72195-72197

341 Suspected diagnosis of ***avascular necrosis*** with:

1) Pain in the hip radiating to the knee; *and*
2) A history of one of the following:
   a) Previous trauma;
   b) Intracapsular fractures;
   c) Alcoholism;
   d) High dose steroid use;
   e) Air embolism from diving, or
   f) Hemoglobinopathies

342 Suspected diagnosis of ***tumor or abscess*** with a bone scan or x-ray suspicious for same.

Code	Criteria	Code	Criteria

Knee MRI/MRA
CPT: 73721-73723

351 Suspected ***anterior cruciate ligament tear*** when x-ray is negative for bony abnormalities, and the intent is to treat aggressively with at least *three* of the following:

1) History of hyperextension injury with immediate swelling, and complaints of giving way or buckling; *or*
2) Four or more weeks of conservative care; *or*
3) Current exam with the following findings: hemarthrosis and\or positive Lockman's and\or positive pivot shift; *or*
4) MRI is necessary to choose treatment option(s).

352 Suspected ***posterior cruciate ligament tear*** when x-ray is negative for bony abnormalities, and the intent is to treat aggressively with at least *two* of the following:

1) History of direct blow to anterior tibia or forced hyperflexion; *or*
2) Four or more weeks of conservative care; *or*
3) Current clinical with *one or more* positive findings: positive drawers, test positive tibial sag.

353 Suspected ***meniscal tear*** when x-ray is negative for bony abnormalities, and the intent is to treat aggressively with at least <u>two</u> of the following:

1) History of twisting injury with subsequent catching, locking, and swelling; *or*
2) Four or more weeks of conservative care; *or*
3) *One or more* of the following exam findings: joint line tenderness, positive McMurrays.

Upper Extremity MRI/MRA
CPT: 73218-73223

361 Suspected diagnosis of ***tumor or abscess*** with a bone scan or x-ray suspicious for same.

Lower Extremity MRI/MRA
CPT: 73718-73723,-73723, 73725

371 Suspected diagnosis of ***tumor or abscess*** with a bone scan or x-ray suspicious for same.

Abdominal MRI/MRA
CPT: 74181-74183, 74185

381 Suspected diagnosis of ***tumor or abscess*** with both of the following:

1) Ultrasound positive for mass on the kidney, pancreas, or liver; *and*
2) Objective evidence of poor renal function.

Other MRI/MRA
All other covered MRI/MRA

390 MRIs/MRAs not meeting expedited criteria, but medically necessary/medically appropriate in accordance with established criteria. Evidence of medical appropriateness must be clearly evidenced by the information in the client's medical record.

Note: If billing for more than one MRI/MRA *for the same reason*, use criteria code 390.

Note: If billing for more than one MRI/MRA *for different reasons*, build two separate expedited prior authorization numbers.

Code	Criteria	Code	Criteria

PET scans are covered when any one of the following PET code criteria sets are met and evidenced in the client's medical record and EPA number is assigned.

PET Scan

CPT codes: 78459, 78608, 78811-78813
DX: 793.1

382 PET imaging regional or whole body when the client has a pulmonary nodule.

383 PET Imaging whole body to diagnose; lung cancer (non small cell), colorectal cancer, melanoma, or lymphoma **when at least one of the following is true:**

1) The PET results may assist in avoiding an invasive diagnostic procedure; or
2) The PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure.

PET Scans

DX: 162.0-162.9, 153.0-154.8, 172.0-172.9, 201.90-202.88

384 PET Imaging whole body for initial staging of; lung cancer (non-small cell), colorectal cancer, melanoma, or lymphoma **when one of the following is true:**

1) The stage of the cancer is unclear after completion of a standard diagnostic work-up that includes conventional imaging (CT, MRI, or ultrasound); or
2) The use of the PET could potentially replace one or more conventional imaging study when it is expected that conventional study information is insufficient for the clinical management of the patient; and
3) The clinical management of the client would differ depending on the stage of the cancer identified.

PET Scans

DX: 172.0-172.9, 201.90-202.88

385 PET Imaging whole body for re-staging of; melanoma, or lymphoma after completion of treatment for **one of the following reasons:**

1) To detect residual disease; or
2) To detect suspected recurrence; or
3) To determine the extent of known recurrence.

386 PET Imaging whole body or regional to diagnose; head and neck cancer (excluding thyroid and CNS cancers), when **at least one of the following is true:**

1) The PET results may assist in avoiding an invasive diagnostic procedure; or
2) The PET results may assist in determining the optimal anatomical location to perform an invasive diagnostic procedure.

PET Scans

DX: 140.0-146.9, 148.0-148.1, 150.0-150.9, 160.0-160.8, 161.0-161.8, 173.0-173.8, 194.0-194.9, 197.3, 197.8, 198.2, 198.89

387 PET Imaging whole body or regional for initial staging of; head and neck cancer (excluding thyroid and CNS cancers), or esophageal cancer when **at least one of the following is true:**

1) The stage of the cancer is unclear after completion of a standard diagnostic work-up that includes conventional imaging (CT, MRI, or ultrasound); or
2) The use of the PET could potentially replace one or more conventional imaging study when it is expected that conventional study information is insufficient for the clinical management of the patient; and
3) The clinical management of the client would differ depending on the stage of the cancer identified.

Code	Criteria

PET Scans
DX: 148.0-148.9, 148.1, 160.0-160.9, 161.0-160.9, 173.0-173.9, 194.0-194.8, 197.3, 198.2, 198.89

388 PET Imaging whole body or regional for re-staging of; head and neck cancer (excluding thyroid and CNS cancers after the completion of treatment for **one of the following**:

1) To detect residual disease;
2) To detect suspected recurrence; or
3) To determine the extent of known recurrence.

PET Scans
DX: 345.11, 345.41, 345.54

389 PET Imaging; metabolic brain imaging for pre-surgical evaluation of refractory seizures.

PET Scans
DX: 410.0-410.9, 414.00-414.07, 414.8

391 PET Imaging; metabolic assessment for myocardial viability when a SPECT study is inconclusive.

PET Scans
DX: 153.0-154.8, 172.0-172.9, 201.90--202.88

392 PET WhBD, gamma cameras only, for one of the following reasons:

1) Recurrence of colorectal or colorectal metastatic cancer;
2) Recurrence of melanoma or metastatic melanoma; or
3) Staging and characterization of lymphoma.

PET Scans
DX: 162.0-162.9

393 PET regional or whole body, gamma camera only, when the study is for **one of the following:**

1) A solitary pulmonary nodule following CT; or
2) Initial staging of pathologically diagnosed non-small cell lung cancer.

PET Scans
DX: 174.0-174.9

394 PET imaging, for breast cancer, full and partial ring, when the study is for *one* of the following:

1) Staging/restaging of local regional recurrence or distant metastases, i.e., staging/restaging after, or prior to, course of treatment; or
2) Evaluation of response to treatment, performed during course of treatment.

PET Scans
DX: 171.4, 171.9, 193, 202.01

395 PET imaging, full and partial ring, for restaging of previously treated thyroid cancer of follicular cell origin following negative I-131 whole body scan.

Medical Admits
CPT: 99221-99223

401 Diagnosis of ***Cellulitis*** (681.00-681.9, 682.0, 682.2-682.9) in a client that received greater than 30 hours of IV antibiotics during the hospitalization and any *one* of the following:

1) Incision & drainage during admit; *or*
2) White Count greater than10 on admit; *or*
3) Persistence or progression of fever, lymphodenopathy, edema, or erythema after a minimum of 24 hours of outpatient antibiotic treatment.

Code	Criteria
402	Diagnosis of ***Abdominal Pain*** (789.00-789.09) in a client with a nasogastric tube and intravenous fluid administration, during the hospital stay, for greater than 30 hours.
403	Diagnosis of ***Dehydration or Electrolyte Imbalances*** (276.0-276.6, 276.8-276.9) in a client with abnormal lab values requiring intravenous electrolyte supplementation, during the hospital stay, for greater than 30 hours.
404	Diagnosis of ***Nausea/Vomiting*** (536.2; 787.00-787.03) in a client: 1) With a nasogastric tube and Intravenous fluid administration, during the hospital stay, for greater than 30 hours; *or* 2) Who is unable to tolerate PO and is treated with intravenous medications, during the hospital stay, for greater than 30 hours.
405	Diagnosis of ***Gastritis*** (535.00-535.61, 558.0-558.9) in a client: 1) With a Nasogastric tube and intravenous fluid administration, during the hospital stay, for greater than 30 hours; *or* 2) Who is unable to tolerate PO and is treated with intravenous medications, during the hospital stay, for greater than 30 hours.
406	Diagnosis of ***headaches*** (784.0**,** 346.00-346.91) in a client receiving intravenous DHE, during the hospital stay, for greater than 30 hours.
407	Diagnosis of ***chronic pancreatitis*** (577.0, 577.1) in a client: 1) With a nasogastric tube and intravenous fluid administration, during the hospital stay, for greater than 30 hours; *or* 2) Who is unable to tolerate PO and is treated with intravenous medications, during the hospital stay, for greater than 30 hours.
408	Diagnosis of ***back pain*** (724.0-724.6, 724.8-724.9, 846.0-847.9) in a client: 1) Failed outpatient treatment; *and* 2) Continued use of intravenous pain medication, during the hospital stay, greater than 30 hours; *or* 3) Continued inability to ambulate after physical therapy intervention greater than 30 hours.
409	Diagnosis of ***constipation*** (560.30, 560.39, 564.00-564.9) in a client: 1) Failed outpatient treatment; *or* 2) Recent abdominal surgery; *and* 3) Extensive inpatient treatment, during the hospital stay, greater than 30 hours.
Other Inpatient Medical Admits	
420	Inpatient medical admits requiring expedited prior authorization and not meeting expedited criteria, but medically necessary/medically appropriate in accordance with established criteria, for continued stay over 24 hours. Medical appropriateness must be clearly evident by the documentation in the client's medical record.
Visual Exam/Refraction (Optometrists/Ophthalmologists only) **CPT:** 92014-92015	
610	**Eye Exam/Refraction - Due to loss or breakage:** For adults within 2 years of last exam when no medical indication exists and **both** of the following are documented in the client's record: 1) Glasses that are broken or lost or contacts that are lost or damaged; **and** 2) Last exam was at least 18 months ago. **Note**: You do not need an EPA # when billing for children or clients with developmental disabilities.

Code	Criteria	Code	Criteria

Dispensing/Fitting Fees for Glasses
CPT: 92340-92342

615 **Glasses (both frames and lenses) – Due to loss or breakage** for adults - within 2 years of last dispensing glasses may be replaced when glasses are broken or lost and **all** of the following are documented in the client's record:

1) Copy of current prescription (less than 18 months old); **and**
2) Date of last dispensing; **and**
3) Both frames and lenses are broken or lost.

Note: You do not need an EPA # when billing for children or clients with developmental disabilities.

Dispensing/Fitting Fees for Frames Only
CPT: 92340, 92341, 92342

618 **Replacement Frames –Due to loss or breakage:** For adults - lost or broken frames may be replaced when **all** of the following are documented in the client's record:

1) No longer covered under the manufacturer's 1 year warranty; **and**
2) Copy of current prescription demonstrating the medical necessity for prescription eye wear; (see pg. C.3) **and**
3) Documentation of broken or lost frames.

Note: You do not need an EPA # when billing for children or clients with developmental disabilities.

619 **Durable Frames** for adults and children - when the following is documented in the client's record:

1) The client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a 12-month period.

620 **Flexible Frames** for adults and children - when the following is documented in the client's record:

1) The client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a 12-month period.

Dispensing/Fitting Fees for Lenses Only
CPT: 92340 - 92342

623 **Replacement eyeglass lenses – Due to loss or breakage:** For adults, lost or broken lenses may be replaced when **all** of the following are documented in the client's record:

1) Copy of current prescription (prescription is less than 18 months old); **and**
2) Date of last dispensing (if known); **and**
3) Documentation of lens damage or loss.

Note: You do not need an EPA # when billing for children or clients with developmental disabilities.

622 **Replacement eyeglass lenses - Due to eye surgery/effects of prescribed medication/diseases affecting vision:** For adults and children - within 2 years of last dispensing when:

1) The client has a stable visual condition (see Definition section); **and**
2) The client's treatment is stabilized; **and**
3) The lens correction must have a 1.0 or greater diopter change between the sphere or cylinder correction in at least one eye; **and**
4) The previous and new refraction must be documented in the client record.

Code	Criteria	Code	Criteria

624 **Replacement eyeglass lenses – Due to headaches/blurred vision/difficulty with school or work:** For adults and children - within 2 years of last dispensing, for refractive changes (provider error is the responsibility of the provider to warranty their work and replace the lens at no charge) when **all** of the following are documented in the client's record:

1) The client has symptoms e.g., headaches, blurred vision, difficulty with school or work; **and**
2) Copy of current prescription (prescription is less than 18 months old for adults); **and**
3) Date of last dispensing, if known; **and**
4) Absence of a medical condition that is known to cause temporary visual acuity changes (e.g. diabetes, pregnancy); **and**
5) A refractive change of at least .75 diopter or greater between the sphere or cylinder correction in at least one eye.

625 **High index eyeglass lenses** for adults and children when **one** of the following is documented in the client's record:

1) A spherical refractive correction of +\- 8.0 diopters or greater; **or**
2) A cylinder correction of +\- 3.0 diopters or greater.

Dispensing/Fitting Fees for Contacts

CPT: 92070, 92310-92317

627 **Replacement Contact Lenses – Due to loss or breakage**: For adults - once every 12 months when contact lenses are lost or damaged **and** the prescription is less than 18 months old.

> **Note**: You do not need an EPA # when billing for children or clients with developmental disabilities.

621 **Replacement Contact Lenses – Due to eye surgery/effects of prescribed medication/diseases affecting vision:** For adults - within 1 year of last dispensing when:

1) The client has a stable visual condition (see Definition section); **and**
2) The client's treatment is stabilized; **and**
3) The lens correction has a 1.0 or greater diopter change in at least one eye between the sphere or cylinder correction; **and**
4) The previous and new refraction are documented in the client record.

> **Note**: You do not need an EPA # when billing for children or clients with developmental disabilities.

Blepharoplasties

CPT: 15822, 15823, and 67901-67908,

630 Blepharoplasty for noncosmetic reasons when *both* of the following are true:

1) The excess upper eyelid skin impairs the vision by blocking the superior visual field;
2) On a central visual field test, the vision is blocked to within 10 degrees of central fixation.

Strabismus Surgery

CPT: 67311-67340

631 Strabismus surgery for clients 18 years of age and older when *both* of the following are true:

1) The client has double vision; and
2) It is not done for cosmetic reasons.

Code	Criteria	Code	Criteria

Physical Therapy

CPT: 97010-97150, 97520-97537, 97750

640 ***An additional 48 Physical Therapy program units*** when the client has already used the allowed program units for the current year and has ***one*** of the following surgeries or injuries:

1) Lower Extremity Joint Surgery;
2) CVA not requiring acute inpatient rehabilitation; or
3) Spine surgery.

641 ***An additional 96 Physical Therapy program units*** when the client has already used the allowed program units for the current year and has recently completed an acute inpatient rehabilitation stay.

Occupational Therapy

CPT: 97110, 97112, 97150, 97520, 97530, 97532, 97533, 97535, 97537

644 ***An additional 12 Occupational Therapy*** visits when the client has used the allowed visits for the current year and has ***one*** of the following:

1) Hand\Upper Extremity Joint Surgery; or
2) CVA not requiring acute inpatient rehabilitation.

645 ***An additional 24 Occupational Therapy*** visits when the client has already used the allowed visits for the current year and has recently completed an acute inpatient rehabilitation stay.

Orthotics

HCPCS: L3000

784 **Foot insert, removable, molded to patient model, "UCB" type, Berkeley Shell, each**

Purchase of one (1) pair per 12-month period for a client 16 years of age or younger allowed if any of the following criteria are met:

1) Required to prevent or correct pronation;
2) Required to promote proper foot alignment due to pronation; or
3) For ankle stability as required due to an existing medical condition such as hypotonia, Cerebral Palsy, etc.

☞ **Note:**

1) If the medical condition does not meet one of the above-specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.

2) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria.

3) If the client only medically requires one orthotic, right or left, prior authorization must be obtained.

HCPCS: **L3030**

780 **Foot insert, removable, formed to patient foot.**

One (1) pair allowed in a 12-month period if one of the following criteria is met:

1) Severe arthritis with pain;
2) Flat feet or pes planus with pain;
3) Valgus or varus deformity with pain;
4) Plantar facitis with pain; or
5) Pronation.

Code	Criteria	Code	Criteria

☞ **NOTE:**

1) If the medical condition does not meet one of the above specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.
2) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria.

HCPCS: **L3310 & L3320**

781 Lift, elevation, heel & sole, per inch.

Allowed for as many inches as required (has to be at least one inch), for a client with a leg length discrepancy, on one shoe per 12-month period.

HCPCS: **L3334**

782 Lift, elevation, heel, per inch

Allowed for as many inches as required (has to be at least one inch), for a client with a leg length discrepancy, on one shoe per 12-month period.

☞ **NOTE:**

1) Lifts are not covered for less than one (1) inch.
2) Lifts are only allowed on one (1) pair of client shoes.
3) If the medical condition does not meet one of the above-specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.
4) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria.

HCPCS: L3215 or L3219

785 Orthopedic footwear, woman's or man's shoes, oxford.

Purchase of one (1) pair per 12-month period allowed if any of the following criteria are met:

1) When one or both shoes are attached to a brace;
2) When one or both shoes are required to accommodate a brace with the exception of L3030 foot inserts;
3) To accommodate a partial foot prosthesis; or
4) To accommodate clubfoot.

☞ **NOTE:**

MAA does not allow orthopedic footwear for the following reasons:

1) To accommodate L3030 orthotics;
2) Bunions;
3) Hammer toes;
4) Size difference (mismatched shoes); or
5) Abnormal sized foot.

MAA-Approved Centers of Excellence (COE)

[Refer to WAC 388-531-0650, WAC 388-531-0700, and WAC 388-531-1600]

The following services must be performed in an MAA-approved Center of Excellence (COE) and **do not require prior authorization**. See the next page for a list of COEs.

- Organ/bone marrow/peripheral stem cell transplants;
- Inpatient Chronic Pain Management; or
- Sleep studies (CPT codes 95805, 95807-95811), only allowed for ICD-9-CM diagnoses 780.51, 780.53, 780.57, or 347 and Bariatric Surgery

☞ **Note:** When billing on a paper HCFA-1500 claim form, note the COE in field 32. When billing electronically, note the COE in the *Comments* section.

MAA-Approved Organ Transplant Centers of Excellence (COE)

[*Refer to WAC 388-531-1750 and WAC 388-550-2000]

APPROVED TRANSPLANT HOSPITALS	ORGAN(S)	CPT CODE
Children's Hospital & Medical Center/Seattle	• Bone Marrow (BMT) (autologous & allogenic) • Peripheral Stem Cell Transplant (PSC-T) • Heart • Liver • Kidney	• 38230, 38240-38242 • 38205-38206, 38240-38242 • 33945 • 47135-47136 • 50360, 50365, 50380
Dorenbacher Children's Hospital/Portland **NW Marrow Transplant Program (PSC-T only)**	• BMT • PSC-T	• 38230, 38240-38242 • 38205-38206, 38240-38242
Fred Hutchinson Cancer Research Center/Seattle	• BMT • PSC-T	• 38230, 38240-38242 • 38205-38206, 38240-38242
Good Samaritan Hospital Medical/Puyallup	• PSC-T	• 38205-38206, 38240-38242
Inland NW Blood Center	• PSC-T	• 38205-38206, 38240-38242
Legacy Good Samaritan Hospital/Portland **(Northwest Marrow Transplant Program)**	• BMT • PSC-T	• 38230, 38240-38242 • 38205-38206, 38240-38242
Mary Bridge Children's Hospital/Seattle	• PSC-T (autologous only)	• 38206, 38242
Oregon Health Sciences University (OHSU)/Portland	• Heart • Liver • Kidney • Pancreas	• 33945 • 47135-47136 • 50360, 50365, 50380 • 48160, 48554
Providence St. Peter Hospital/Olympia	• PSC-T	• 38206, 38240-38242
Sacred Heart Medical Center/Spokane	• Kidney • Heart • Heart/Lung(s) • Lung	• 50360, 50365, 50380 • 33945 • 33935 • 32851-32854
Seattle Cancer Care Alliance/Seattle	• BMT • PSC-T	• 38230, 38240-38242 • 38205-38206, 38240-38242
St. Joseph's Hospital/Tacoma	• BMT (autologous only) • PSC-T	• 38230, 38242 • 38205-38206, 38240-38242

MAA-Approved Organ Transplant Centers of Excellence (COE) (Cont.)

[*Refer to WAC 388-531-1750 and WAC 388-550-2000]

APPROVED TRANSPLANT HOSPITALS	ORGAN(S)	CPT CODE
Swedish Medical Center/Seattle	• Kidney • PSC-T	• 50360, 50365, 50380 • 38231, 38240-38241
University of Washington Medical Center/Seattle	• BMT • PSC-T • Heart • Heart/Lung(s) • Lung • Kidney • Liver • Pancreas	• 38230, 38240-38241 • 38231, 38240-38241 • 33945 • 33935 • 32851-32854 • 50360, 50365, 50380 • 47135-47136 • 48160, 48554
Virginia Mason Hospital/Seattle	• Kidney • Pancreas • BMT • PSC-T	• 50360, 50365, 50380 • 48160, 48554 • 38230, 38240-38241 • 38231, 38240-38241

MAA-Approved Sleep Study Centers

[Refer to WAC 388-531-1500]

MAA Approved Sleep Centers	Location
ARMC Sleep Apnea Laboratory	Auburn Regional Medical Center - Auburn, WA
Columbia Sleep Lab	Richland, WA.
Diagnostic Sleep Disorder Program Center	Children's Hospital and Medical - Bellevue, WA
Eastside Sleep Disorder Clinic	Overlake Hospital Medical Center - Bellevue, WA
Highline Sleep Disorders Center	Highline Community Hospital - Seattle, WA
Holy Family Sleep Disorder Center	Holy Family Hospital -Spokane, WA
Kathryn Severyns Dement Sleep Disorders Center	St. Mary's Medical Center - Walla Walla, WA
Multi Care Sleep Disorders Center	Tacoma General Hospital/ or Mary Bridge Children's Hospital - Tacoma, WA
Olympic Medical Center—Sleep Center	Olympic Medical Center Port Angeles, WA
Providence Everett Sleep Disorder Center	Providence Everett Medical Center - Everett, WA.
Richland Sleep Lab/Center	Richland Sleep Center – Richland, WA
Sleep Center at Memorial	Yakima Memorial Hospital – Yakima, WA
Sleep Center for Southwest Washington	Providence St. Peter - Olympia, WA
Sleep Disorders Center Legacy Good Samaritan Hospital and Medical Center	Legacy Good Samaritan Hospital and Medical Center - Portland, OR
Sleep Disorders Center of Harrison Hospital	Harrison Hospital - Bremerton, WA
Sleep Disorders Center Virginia Mason Medical Center	Virginia Mason Medical Center - Seattle, WA
Sleep Related Breathing Disorders Laboratory St Clare Hospital	St. Clare Hospital - Tacoma, WA
Sleep Studies Laboratory Mid Columbia Medical Center	Mid Columbia Medical Center - Dalles, OR
St. Joseph Regional Medical Center Sleep Lab	St. Joseph Regional Medical Center - Lewiston, ID

MAA Approved Sleep Centers	Location
Swedish Sleep Medicine Institute	Providence Swedish or Swedish First Hill - Seattle, WA
The Sleep Institute of Spokane	Sacred Heart Medical Center or 104 W. 5th Suite 400 W - Spokane, WA
University of Washington Sleep Disorders Center\Harborview Medical Center	Harborview Medical Center - Seattle, WA
Valley Medical Center--Sleep Center	Valley Medical Center Renton, WA
Vancouver Sleep Disorders Center	Vancouver Neurology - Vancouver, WA

Providers must:

- Use CPT codes 95805 and 95807-95811 for sleep study services.

- Enter the location of the approved sleep center where the sleep study/polysomnogram or multiple sleep latency testing was performed. (Refer to previous page for appropriate location of MAA-approved sleep center.) Enter the information into the *Comments* section of the claim form.

☞ **Note**: All sleep studies are limited to Obstructive Sleep Apnea, ICD-9-CM diagnosis codes **780.51, 780.53, 780.57,** or Narcolepsy **347.00-347.11.**

MAA-Approved Inpatient Pain Clinics

MAA-Approved Inpatient Pain Clinic
St. Joseph Hospital & Health Care Center, Tacoma

MAA-Approved Hospitals for Bariatric Surgery

MAA covers medically necessary bariatric surgery in an approved hospital with a bariatric surgery program in accordance with WAC 388-531-1600. Prior authorization is required. To begin the authorization process, providers should fax MAA a completed "Fax/Written Request Basic Information" form [DSHS # 13-756] to:

MAA – Division of Medical Management
Attn: Provider Request/Client Notification Unit
PO Box 45506
Olympia, WA 98504-5506
FAX: (360) 586-1471

Site of Service (SOS) Payment Differential

How are fees established for professional services performed in facility and non-facility settings?

Based on the Resource Based Relative Value Scale (RBRVS) methodology, MAA's fee schedule amounts are established using three relative value unit (RVU) components: work, practice expense, and malpractice expense. MAA uses two levels of practice expense components to determine the fee schedule amounts for reimbursing professional services. This may result in two RBRVS maximum allowable fees for a procedure code. These are:

- **Facility setting maximum allowable fees (FS Fee) -** Paid when the provider performs the services in a facility setting (e.g., a hospital or ambulatory surgery center) and the cost of the resources are the responsibility of the facility; or

- **Non-facility setting maximum allowable fees (NFS Fee) -** Paid when the provider performs the service in a non-facility setting (e.g., office or clinic) and typically bears the cost of resources, such as labor, medical supplies, and medical equipment associated with the service performed.

Some services, by nature of their description, are performed only in certain settings and have only one maximum allowable fee per code. Examples of these services include:

- Evaluation and management (E&M) codes which specify the site of service within the description of the procedure codes (e.g., initial hospital care); and
- Major surgical procedures that are generally performed only in hospital settings.

How does the site of service payment policy affect provider reimbursements?

Providers billing professional services are reimbursed at one of two maximum allowable fees, depending on where the service is performed.

Does MAA reimburse providers differently for services performed in facility and non-facility settings?

When a provider performs a professional service in a facility setting, MAA makes two payments - one to the performing provider and another to the facility. The payment to the provider (FS Fee) includes the provider's professional services only. A separate payment is made directly to the facility where the service took place, which includes payment for necessary resources. The FS Fee excludes the allowance for resources that are included in the payment to the facility. Reimbursing the lower FS Fee to the performing provider when the facility is also reimbursed eliminates duplicate payment for resources.

When a provider performs a professional service in a non-facility setting, MAA makes only one payment to the performing provider. The payment to the provider (NFS Fee) includes the provider's professional services and payment for necessary resources.

When are professional services reimbursed at the facility setting maximum allowable fee?

Providers are reimbursed at the FS Fee when MAA also makes a payment to a facility. In most cases, MAA follows Medicare's determination for using the FS Fee. Professional services billed with the following place of service codes are reimbursed at the FS Fee:

FACILITY SETTING

Place of Service Code	Place of Service Description
06	Indian Health Service – provider based
08	Tribal 638 – provider based
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgery Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
34	Hospice
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
56	Psychiatric Residential Treatment Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility

HCPCS Code	Brief Description
A4313	Insertion tray without drainage bag
A4314	Insertion tray with drainage bag
A4315	Insertion tray with drainage bag
A4316	Insertion tray with drainage bag
A4320	Irrigation tray for bladder
A4330	Perianal fecal collection pouch
A4335*	Incontinence supply; miscellaneous
A4338*	Indwelling catheter; Foley type
A4340*	Indwelling catheter; Spec type
A4344*	Indwelling catheter; Foley type
A4346*	Indwelling catheter; Foley type
A4347*	Male external catheter
A4351	Intermittent urinary catheter
A4352	Intermittent urinary catheter
A4353	Catheter insert tray with cath/tube/bag
A4354	Insertion tray with drainage bag
A4355	Irrigation tubing set
A4356*	External urethral clamp device
A4357*	Bedside drainage bag, day or night
A4358*	Urinary leg bag; vinyl
A4359*	Urinary suspensory, without leg bag
A4361*	Ostomy faceplate
A4362*	Skin barrier; solid, 4 x 4
A4364*	Adhesive for ostomy or catheter
A4365*	Adhesive remover wipes, per 50
A4367*	Ostomy belt
A4368*	Ostomy filter, each
A4397	Irrigation supply; sleeve
A4398*	Irrigation supply; bags
A4399*	Irrigation supply; cone/catheter
A4400*	Ostomy irrigation set
A4402	Lubricant

HCPCS Code	Brief Description
A4404*	Ostomy rings
A4421*	Ostomy supply; miscellaneous
A4455	Adhesive remover or solvent
A4465	Non-elastic binder for extremity
A4470	Gravlee jet washer
A4480	Vabra aspirator
A4550	Surgical tray
A4556	Electrodes (e.g., apnea monitor)
A4557	Lead wires (e.g., apnea monitor)
A4558	Conductive paste or gel
A4647	Supply of paramagnetic contrast material (e.g., gadolinium)
A4649	Surgical supply; miscellaneous
A5051*	Ostomy pouch, closed; with barrier
A5052*	Ostomy pouch, closed; without barrier
A5053*	Ostomy pouch, closed; use on faceplate
A5054*	Ostomy pouch, closed; use on barrier
A5055*	Stoma cap
A5061*	Ostomy pouch, drainable; with barrier
A5062*	Ostomy pouch, drainable; without barrier
A5063*	Ostomy pouch, drainable; use on barrier
A5071*	Pouch, urinary; with barrier
A5072*	Pouch, urinary; without barrier
A5073*	Pouch, urinary; use on barrier
A5081*	Continent device ; plug
A5082*	Continent device ; catheter
A5093*	Ostomy accessory; convex insert
A5102*	Bedside drainage bottle
A5105*	Urinary supensory; with leg bag
A5112*	Urinary leg bag; latex

HCPCS Code	Brief Description
A5113*	Leg strap; latex, per set
A5114*	Leg strap; foam or fabric
A5119*	Skin barrier; wipes, box per 50
A5121*	Skin barrier; solid, 6 x 6
A5122*	Skin barrier; solid, 8 x 8
A5126*	Adhesive; disc or foam pad
A5131*	Appliance cleaner
A6021	Collagen dressing <=16 sq in
A6022	Collagen drsg>6<=48 sq in

HCPCS Code	Brief Description
A6023	Collagen dressing >48 sq in
A6024	Collagen dsg wound filler
A6025	Silicone gel sheet, each
A6154	Wound pouch, each
A6231	Hydrogel dsg <=16 sq in
A6232	Hydrogel dsg>16<=48 sq in
A6233	Hydrogel dressing >48 sq in
99070	Special supplies

Supplies Reimbursed Separately When Dispensed from a Provider's Office/Clinic

Miscellaneous Supplies

HCPCS Code	Brief Description
A4250	Urine test or reagent strips
A4561	Pessary rubber, any type
A4562	Pessary, nonrubber, any type
A4565	Slings
A4570	Splint
L8615-L8622	Miscellaneous DME supply, accessory, and/or service component of another HCPCS code. **(To be used only for cochlear implant replacement parts. PA is required for the replacement parts and is manually priced by MAA's authorization department.)**

Casting Materials

Bill the appropriate HCPCS code (Q4001-Q4049) for fiberglass and plaster casting materials. Do not bill for the use of a cast room. Use of a cast room is considered part of a provider's practice expense.

Metered Dose Inhalers and Accessories

HCPCS Code	Brief Description
A4614	Peak flow meter
A4627	Spacer bag, or reservoir, with/ without mask (for use with metered does inhaler)

Inhalation Solutions

Refer to the fee schedule (Section L) for those specific codes for inhalation solutions that are reimbursed separately.

Radiopharmaceutical Diagnostic Imaging Agents

Refer to the fee schedule (Section L) for those specific codes for imaging agents that are reimbursed separately.

Miscellaneous Prosthetics & Orthotics

HCPCS Code	Brief Description
L0120	Collar-philadelphia child
L0210	Thoracic, rib belt
L0220	Thoracic, rib belt, custom fabricated
L0515	Industrial back support *(not covered for scoliosis)*
L1800	Stabiliz knee sleeve-universal
L1810	Knee brace hinged
L1815	Roadrunner knee brace
L1820	Action neoprene brace, knee
L1830	Knee immobilizer 24" universal
L1902	Boot-walkabout med/large
L1906	Canvas ankle brace
L3030	Hapad metatarsal pad
L3334	Achilles lift
L3350	Adjustable peel-off heel lift
L3360	Achilles heel wedge/west walkr
L3650	Shoulder abduction pillow
L3700	Neoprene butress elbow, s-m-l
L3807	WHFO, extension assist, with inflatable palmer air support, with or without thumb Extension
L3908	Wrist comfort form all sizes
L3909	Wrist Orthosis
L3928	Lmb 504 extension
L4350	Air support - purple med/large
L4360	Walker, pneumatic s-m-l **PA required.**
L4380	Aircast infrapatellar band
L4386	Diabetic walker **PA required.**
L8000	Post mastedtomy implants bra
L8010	Breast binder
L8600	Breast implants

Urinary Tract Implants

See important policy limitations for urinary tract implants on page F.24.

HCPCS Code	Brief Description
L8603	Collagen implant, urinary tract, per 2.5 ml syringe
L8606	Synthetic implant, urinary tract, per 1 ml syringe

☞ **Note:** MAA does not reimburse providers for L8603 and L8606 if the implants are done outside the physician's office.

MAA covers the first three (3) implants only, using a combination of L8603 and/or L8606, per client. Each 2.5 ml syringe of L8603 or each 1 ml syringe of L8606 is one implant.

Podiatry and Orthopedic Surgeons

The following codes are payable only to Podiatrists and Orthopedic Surgeons:

HCPCS Code	Brief Description
A5500	Diab shoe for density insert
A5501	Diabetic custom molded shoe
A5503	Diabetic shoe w/roller/rocker
A5504	Diabetic shoe with wedge
A5505	Diab shoe w/metatarsal bar
A5506	Diabetic shoe w/offset heal
A5507	Modification diabetic shoe (requires PA)
K0628	Direct heat form shoe insert
K0629	Custom fab molded shoe inser
L1902	Boot-walkabout med/large
L1906	Canvas ankle brace
L3000	Ft insert ucb berkeley shell. **EPA required.**

HCPCS Code	Brief Description
L3030	Foot arch support remov prem. **EPA required.**
L3100	Hallus-valgus nght dynamic s
L3140	Abduction rotation bar shoe
L3150	Abduct rotation bar w/o shoe
L3170	Foot plastic foot stabilizer. **EPA required.**
L3215	Orthopedic ftwear ladies oxf. **EPA required.**
L3219	Orthopedic mens shoes oxford. **EPA required.**
L3230	Custom shoes depth inlay. **PA required.**
L3310	Shoe lift elev heel/sole neo. **EPA required.**
L3320	Shoe lift elev heel/sole cor. **EPA required.**
L3334	Shoe lifts elevation heel /i. **EPA required.**
L3340	Shoe wedge sach. **PA required.**
L3350	Shoe heel wedge. **PA required.**
L3360	Shoe sole wedge outside sole. **PA required.**
L3400	Shoe metatarsal bar wedge ro. **PA required.**
L3410	Shoe metatarsal bar between. **PA required.**
L3420	Full sole/heel wedge between. **PA required.**
L3430	Shoe heel count plast reinfor
L4350	Air support – purple med/large
L4360	Walker, pneumatic s-m-l **PA required.**
L4380	Aircast infrapatellar band
L4386	Diabetic walker **PA required.**

Injectable Drug Codes

MAA's fees for injectable drug codes are the maximum allowances used to reimburse covered drugs and biologicals administered in a provider's office. MAA follows Medicare's payment policy to set the maximum allowances.

Effective for dates of service on and after January 1, 2005, MAA adopted Medicare's new drug pricing methodology of 106% of the Average Sales Price (ASP). If a Medicare fee is unavailable for a particular drug, MAA prices the drug at 86% of the Average Wholesale Price (AWP). MAA obtains the AWP for these drugs from Medicare's Single Drug Pricer (SDP). MAA updates the rates each time Medicare's rate is updated, up to once per quarter. Unlike Medicare, the MAA effective dates are based on dates of service, not the date the claim is received. For HCPCS codes where Medicare does not establish a rate, MAA determines the maximum allowances for covered drugs using the following methodology:

1. For a single-source drug or biological, the AWP equals the AWP of the single product.

2. For a multi-source drug or biological, the AWP is equal to the median AWP of all of the generic forms of the drug or biological, or the lowest brand name product AWP, whichever is less. A "brand-name" product is defined as a product that is marketed under a labeled name that is other than the generic chemical name for the drug or biological.

3. After determining the AWP according to #1 and #2 above, MAA multiplies the amount by 0.86 to arrive at the fee schedule maximum allowance.

When billing for injectable drugs and biologicals, providers must use the description of the procedure code to determine the units, and include the correct number of units on the claim form to be reimbursed the appropriate amount. For drugs priced at "acquisition cost," providers must:

- Include a copy of the manufacturer's invoice for each line item in which **billed charges** exceed $1,100.00; or
- Retain a copy of the manufacturer's invoice in the client's record for each line item in which **billed charges** are equal to or less than $1,100.00.

Do not bill using unclassified or unspecified drug codes unless there is no specific code for the drug being administered. The National Drug Code (NDC) and dosage given to the client must be included with the unclassified or unspecified drug code for coverage and payment consideration.

HCPCS codes J8499 and J8999 for oral prescription drugs are not covered.

Injectable drugs can be injected subcutaneously, intramuscularly, or intravenously. The injectable drugs can be billed only from the provider's office supply. The name, strength, and dosage of the drug must be documented and retained in the client's record.

Chemotherapy Drug (J9000-J9998)

- Bill number of units used based on the description of the drug code. For example, if 250 mg of Cisplatin (J9062) is given to the client, the correct number of units is five (5).
- Effective for dates of service on and after January 1, 2005, MAA adopted Medicare's new drug pricing methodology of 106% of the Average Sales Price (ASP). If a Medicare fee is unavailable for a particular drug, MAA continues to price the drug at 86% of the Average Wholesale Price (AWP).

All Other Drugs

- Bill number of units used based on the description of the drug code. For example, if 20 mg of Hyalgan (J7316) is given to the client, the correct number of units is four (4).
- Claims with HCPCS code J3490 must include the NDC and the amount of the drug administered to the client in the Comments section of the claim form, and must be billed with one unit only.
- Effective for dates of service on and after January 1, 2005, MAA adopted Medicare's new drug pricing methodology of 106% of the Average Sales Price (ASP). If a Medicare fee is unavailable for a particular drug, MAA continues to price the drug at 86% of the Average Wholesale Price (AWP).

Limitations on coverage for certain injectable drugs are listed below:

Procedure Code	Brief Description	Limitation Restricted to ICD-9-CM
J0637	Caspofungin acetate	117.3 (aspergillosis)
J0725	Chorionic gonadotropin/1000u	752.51 (Undescended testis)
J1055	Medroxyprogester acetate inj (depo provera)	Females-only diagnoses V25.02 or V25.3 or V25.49 or V25.9. (contraceptive mgmt) Males-diagnosis must be related to cancer
J1212	Dimethyl sulfoxide 50% 50 ML	595.1 (chronic intestinal cystitis)
J1595	Injection glatiramer acetate	340 (multiple sclerosis)
J1756	Iron sucrose injection	585(chronic renal failure)
J2324	Nesiritide	No diagnosis restriction. Restricted use only to cardiologists
J2501	Paricalcitol	585 (chronic renal failure)
J2916	Na ferric gluconate complex	585 (chronic renal failure)
J3420	Vitamin b12 injection	123.4, 151-154.8, 157-157.9, 197.4-197.5, 266.2, 281.0-281.3, 281.9, 284.0, 284.8-284.9, 555.9, 579, 648.2
J3465	Injection, voriconazole	117.3 (aspergillosis)

Procedure Code	Brief Description	Limitation Restricted to ICD-9-CM
J3487	Zoledronic acid	198.5, 203-203.01, and 275.42 (hypercalcemia)
J9041	Bortezomib injection	203.00-203.01 (multiple myeloma and immunoproliferative neoplasms)
Q3025	IM inj interferon beta 1-a	340 (multiple sclerosis)
Q3026	Suc inj interferon beta 1-a	340 (multiple sclerosis)
Q4077	Treprostinil, 1 mg	416-416.9 (chronic pulmonary heart disease)

Prior Authorization

Drugs requiring written/fax prior authorization are noted in the fee schedule with a "PA" next to them. For information on how to request prior authorization, refer to Section I.

Rounding of Units

The following guidelines should be used to round the dosage given to the client to the appropriate number of units for billing purposes:

I. Single-Dose Vials:

For single-dose vials, bill the total amount of the drug contained in the vial(s), including partial vials. Based on the unit definition for the HCPCS code, MAA reimburses providers for the total number of units contained in the vial. **For example:**

> If a total of 150 mg of Etoposide is required for the therapy and two 100 mg single dose vials are used to obtain the total dosage, the total of the two 100 mg vials is reimbursed. In this case, the drug is billed using HCPCS code J9181 (Etoposide, 10 mg). If MAA's maximum allowable fee is $4.38 per 10 mg unit, the total allowable is $87.60 (200 mg divided by 10 = 20 units x $4.38).

II. Billing for Multi-Dose Vials:

For multi-dose vials, bill **only** the amount of the drug administered to the client. Based on the unit definition (rounded up to the nearest whole unit) of the HCPCS code, MAA reimburses providers for only the amount of drug administered to the client. **For example:**

> If a total of 750 mg of Cytarabine is required for the therapy and is taken from a 2,000 mg multi-dose vial, only the 750 mg administered to the client is reimbursed. In this case, the drug is billed using HCPCS code J9110 (Cytarabine, 500 mg). If MAA's maximum allowable fee is $23.75 per 500 mg unit, the total allowable is $47.50 [750 mg divided by 500 = 2 (1.5 rounded) units x $23.75].

III. Unlisted Drugs (J3490 and J9999)

When it is necessary to bill MAA for a drug using an unlisted drug code, providers must report the National Drug Code (NDC) of the drug administered to the client. MAA uses the NDC when unlisted drug codes are billed to appropriately price the claim. Claims *must* include:

- The dosage (amount) of the drug administered to the client;
- The 11-digit NDC of the office-administered drug; and
- One unit of service.

For claims billed using a paper HCFA-1500 claim form, list the required information in field 19 of the claim form.

For claims billed using an electronic HCFA-1500 claim form, list the required information in the *Comments* section of the claim form.

For claims billed using an electronic 837P claim form, list the required NDC information in DRUG IDENTIFICATION Loop 2410, LIN02, and LIN03. List the dosage given to the client in the "*Comment*" section of the claim form.

☞ **Note**: If there is an assigned HCPCS code for the administered drug, providers **must bill** MAA using the appropriate HCPCS code. ***DO NOT*** bill using an unlisted drug code for a drug that has an assigned HCPCS code. MAA will recoup payment for drugs paid using an unlisted drug code if an assigned HCPCS code exists for the administered drug.

The list of all injectable drug codes and maximum allowable fees are listed in the fee schedule section (Section J).

CPT/HCPCS Modifiers

[Refer to WAC 388-531-1850(10) and (11)]

Italics indicate additional MAA language not found in CPT.

21: **Prolonged Evaluation and Management Services***: For informational purposes only; no extra allowance is allowed.*

22: **Unusual Procedural Services**: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure code number. *This modifier is not to be used to report procedure(s) complicated by adhesion formation, scarring, and/or alteration of normal landmarks due to late effects of prior surgery, irradiation, infection, very low weight or trauma.*

For informational purposes only; no extra allowance is allowed.

23: **Unusual Anesthesia**: *For informational purposes only; no extra allowance is allowed.*

24: **Unrelated Evaluation and Management (E&M) by the Same Physician During a Postoperative Period**: The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) ***unrelated*** to the original procedure. This circumstance may be reported by adding the modifier 24 to the appropriate level of E&M service. *Payment for the E&M service during postoperative period is made when the reason for the E&M service is unrelated to original procedure.*

25: **Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure**: The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the client's condition required a significant, separately identifiable E&M service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed. This circumstance may be reported by adding the modifier 25 to the appropriate level of E&M service. *Payment for the E&M service is the billed charge or MAA's maximum allowable, whichever is less.*

26: **Professional Component**: Certain procedures are a combination of professional and technical components. When only the professional component is reported, the service is identified by adding modifier 26 to the procedure code.

TC: **Technical Component**: Certain procedures are a combination of professional and technical components. When only the technical component is reported, the service is identified by adding modifier TC to the procedure code. *A contract with MAA is required if services are performed in a hospital setting.*

32: **Mandated Services**: *For informational purposes only; no extra allowance is allowed.*

47: **Anesthesia By Surgeon**: *Not covered by MAA.*

50: **Bilateral Procedure**: Unless otherwise identified in the listing, bilateral procedures that are performed at the same operative session should be identified by adding this modifier to the appropriate five-digit code describing the first procedure.

For surgical procedures typically performed on both sides of the body, payment for the E&M service is the billed charge or MAA's maximum allowable, whichever is less.

For surgical procedures that are typically performed on one side of the body, but performed bilaterally in a specific case, payment is 150% of the global surgery fee for the procedure.

51: **Multiple Procedures**: *When multiple surgeries are performed at the same operative session, total payment is equal to the sum of the following: 100% of the highest value procedure; 50% of the global fee for each of the second through fifth procedures. More than five procedures require submission of documentation and individual review to determine the payment amount.*

52: **Reduced Services**: Under certain circumstances, a service or procedure is partially reduced at the physician's discretion. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of the modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. *Using this modifier does not reduce the allowance to the provider. Note: Modifier 52 may be used with computerized tomography procedure codes for a limited study or a follow-up study.*

53: **Discontinued Procedure**: Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances, or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.

Use of modifier 53 is allowed for all surgical procedures. Modifier 53 is a payment modifier when used with CPT code 45378 and HCPCS codes G0105 and G0121 only. It is "information only" for all other surgical procedures.

54, 55, 56 – Providers providing less than the global surgical package should use modifiers 54, 55, & 56. *These modifiers are designed to ensure that the sum of all allowances for all practitioners who furnished parts of the services included in a global surgery fee do not exceed the total amount of the payment that would have been paid to a single practitioner under the global fee for the procedure. The payment policy pays each physician directly for that portion of the global surgery services provided to the client. The breakdown is as follows:*

54: **Surgical Care Only**: When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number. *A specific percentage of the global surgical payment in the fee schedule is made for the surgical procedure only.*

55: **Postoperative Management Only**: When one physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component may be identified by adding the modifier 55 to the usual procedure number. *A specific percentage of the global surgical payment in the fee schedule is made for the surgical procedure only.*

56: **Preoperative Management Only**: When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure, the preoperative component may be identified by adding the modifier 56 to the usual procedure number. *A specific percentage of the global surgical payment in the fee schedule is made for the surgical procedure only.*

57: **Decision for Surgery**: An evaluation and management (E&M) service provided the day before the day of surgery that resulted in the initial decision to perform the surgery, may be identified by adding the modifier 57 to the appropriate level of E&M service. *This does not apply to minor surgeries (those with a follow-up period of less than 90 days).*

58: **Staged or Related Procedure or Service by the Same Physician During the Postoperative Period**: The physician may need to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding the modifier 58 to the staged or related procedure. *NOTE: This modifier is not used to report the treatment of a problem that requires a return to the operating room. See modifier 78.*

59: **Distinct Procedural Service**: The physician must indicate that a procedure or service was distinct or separate from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site, separate lesion, or separate injury (or area of surgery in extensive injuries). *This modifier is for informational purchases only; no extra allowance is allowed.*

62: **Two Surgeons**: Under certain circumstances, the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical procedure. Under such circumstances, separate services may be identified by adding modifier 62 to the procedure code used by each surgeon for reporting his/her services. *Payment for this modifier is 125% of the global surgical fee in the fee schedule. The payment is divided equally between the two surgeons. No payment is made for an assistant surgeon.*

66: **Team surgery**: *For informational purposes only; no extra allowance is allowed.*

76: **Repeat Procedure by Same Physician**: The physician may need to indicate that a procedure or service was repeated. This may be reported by adding the modifier 76 to the repeated service.

77: **Repeat Procedure by Another Physician**: *For informational purposes only; no extra allowance is allowed.*

78: **Return to the Operating Room for a Related Procedure During the Postoperative Period**: The physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding the modifier 78 to the related procedure. ***When multiple procedures are performed, use modifier 78 on EACH detail line.*** *Payment for these procedures is the percentage of the global package for the intra-operative services. Assistant surgeons and anesthesiologists must use modifier 99 to indicate an additional operating room procedure.*

79: **Unrelated Procedure or Service by the Same Physician During the Postoperative Period**: The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using the modifier 79.

80: **Assistant Surgeon**: Surgical assistant and/or physician assistant services must be identified by adding modifier 80 to the usual procedure code(s). *A physician assistant, employed by a physician, must use the physician's provider number and must bill on the same claim form as the physician/surgeon. Payment is 20% of the maximum allowance.*

81: **Minimum Assistant Surgeon**: Minimum surgical assistant services are identified by adding the modifier 81 to the usual procedure number. *Payment is 20% of the maximum allowance.*

82: **Assistant Surgeon (When Qualified Resident Surgeon Not Available)**: The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s). *Payment is 20% of the maximum allowance.*

90: **Reference (Outside) Laboratory**: When laboratory procedures are performed by a lab other than the referring lab, the procedure must be identified by adding modifier 90 to the procedure code. *The reference lab provider number must be entered in the performing number field on the HCFA-1500 claim form or electronic claim record. The reference lab must be CLIA-certified.*

91: **Repeat Clinical Diagnostic Laboratory Test** performed on the same day to obtain subsequent report test value(s). *Modifier 91 must be used when repeat tests are performed on the same day, by the same provider to obtain reportable test values with separate specimens taken at different times, only when it is necessary to obtain multiple results in the course of treatment. When billing for a repeat test, use modifier 91 with the appropriate procedure code.*

99: **Multiple Modifiers**: Under certain circumstances, two or more modifiers may be necessary to completely describe a service. *Modifier 99 must be used **only when two or more modifiers affect pricing** (applicable modifiers listed below). Modifier 99 must be added to the basic procedure, and all applicable modifiers from the list below **must** be listed in field 24D.* ***Modifier 99 must be the first modifier listed on the claim.***

26	Professional component
50	Bilateral surgery
53	Discontinued procedure
54	Surgical care only
55	Postoperative management only
56	Preoperative management only
62	Two surgeons
66	Surgical team
78	Return to operating room for related procedure during post-op period
80	Assistant surgeon
81	Minimum assistant surgeon
82	Assistant surgeon (when qualified resident surgeon not available)
91	Repeat clinical diagnostic lab, same day
AA	Anesthesia perf by Anesgst
AD	MD supervision, over 4 anes proc
HA	Children's services
LT	Left
RT	Right
ST	Major trauma
TC	Technical component
TG	Complex/high level of care
TH	Obstetrical treatment/service, prenatal or postpartum
QK	Med dir 2-4 cncrnt anes proc
QX	CRNA svc w/md med direction
QY	Medically directed CRNA
QZ	CRNA svc w/o med dir by md

LT **Left Side**: Used to identify procedures performed on the left side of the body. *MAA requires this modifier with some procedure codes for proper reimbursement.*

QP **Documentation is on file showing that the lab test(s) was ordered individually or ordered as a CPT recognized panel other than automated profile codes**. *This modifier is now used **FOR INFORMATION ONLY**. Internal control reimbursement methodology for automated multi-channel test is applied. This modifier is not appropriate to use when billing for repeat tests or to indicate not as a panel.*

Q6 **Physician Services**: Services furnished by a locum tenens physician. *For informational purposes only; no extra allowance is allowed.*

RT **Right Side**: Used to identify procedures performed on the right side of the body. *MAA requires this modifier with some procedure codes for proper reimbursement.*

SL **State-supplied Vaccine**: *This modifier must be used with those immunization procedure codes indicated in section C to identify those immunization materials obtained from the Department of Health (DOH).*

Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in MAA's billing instructions.

- MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services;
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria; or
  - ✓ The date an MAA managed care plan or Basic Health Plus client's premium has been recouped by MAA.

- MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

---

[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

- Providers may **resubmit, modify, or adjust** any timely initial claim, *except* prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee must I bill MAA?

Bill MAA your usual and customary fee.

How do I bill for multiple services?

If multiples of the same procedure are performed on the same day, providers must bill the appropriate modifier (if applicable) and must bill the services on the same claim form to be considered for payment.

Third-Party Liability

Bill the insurance carrier(s) indicated on the client's DSHS Medical ID Card prior to sending the claim to MAA. An insurance carrier's time limit for claim submissions may be different than MAA's. It is your responsibility to meet MAA's and the insurance carrier's requirements relating to billing time limits, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report (RA) for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA; or
- Attach the insurance carrier's statement.

Third-party carrier codes are available on the Internet at http://maa.dshs.wa.gov/LTPR, or by calling the Coordination of Benefits Section at 1-800-562-6136.

Primary Care Case Management (PCCM) Clients

Clients who obtain care with a PCCM will have a "PCCM" identifier in the HMO column. These clients must obtain their services through the PCCM. The PCCM is responsible for coordination of care just like the PCP is in a plan setting. ***Please refer to the client's DSHS Medical ID card for the PCCM***. When billing MAA, place the PCCM's provider number in the referring provider field.

Note:	**Newborns of clients who are connected with a PCCM are fee-for-service until a PCCM has been chosen for the newborn.**

How do I bill for clients eligible for Medicare and Medicaid?

If a client is eligible for both Medicare and Medicaid, **you must *first* submit a claim to Medicare and accept assignment within Medicare's time limitations.** MAA may make an additional payment after Medicare reimburses you.

- If the Medicare EOMB shows Medicare has allowed any of the charges (whether applied to the copay or deductible) on the claim, the provider must bill MAA within six months of the date Medicare processes the claims.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claims (see page M.1).

Medicare Part A

Medicare Part A is a health insurance program for:

- Individuals who are 65 years of age and older;
- Certain individuals with disabilities (younger than 65 years of age); or
- Individuals with End-Stage Renal Disease (permanent kidney failure requiring dialysis or transplant).

Medicare Part A helps individuals pay for hospital stays, skilled nursing facilities, hospice and some home health care. Check the client's red, white and blue Medicare card for the words "Part A (hospital insurance)" in the lower left corner of the card to determine if the client has Medicare Part A coverage.

Under Part A, Medicare will pay its allowed charges, minus any deductible and/or coinsurance, when appropriate.

> Payment for services rendered to Qualified Medicare Beneficiaries (QMBs) is limited to the Medicare payment if the Medicare payment exceeds the amount MAA would pay for the same service had the service been reimbursed under the ratio of costs-to-charges (RCC) payment methodology (whether normally reimbursed using the DRG or RCC methodologies).

When billing Medicare:

- Indicate *Medicaid* and include the patient identification code (PIC) on the claim form as shown on the client's DSHS Medical ID card. Enter the Medical Assistance provider number.
- Accept assignment.
- If Medicare has allowed the service, in most cases Medicare will forward the claim to MAA. MAA then processes the claim for any supplemental payments.
- If Medicare does not forward your claim to MAA **within 30 days** from its statement date, send the UB-92 claim form and a copy of the Part A Explanation of Medical Benefits (EOMB) to MAA for processing (see *Important Contacts* for address).
- When Part A services are totally disallowed by Medicare but are covered by MAA, bill MAA on the UB-92 claim form and attach copies of Medicare's EOMB with the denial reasons.

Note:

- ✓ **Medicare/Medicaid billing claims must be received by MAA within six (6) months of Medicare's EOMB paid date.**
- ✓ **A Medicare Remittance Notice or EOMB must be attached to each claim.**

Medicare Part B

Benefits covered under Part B include **physician, outpatient hospital, home health, durable medical equipment, and other medical services and supplies** not covered under Part A.

When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on the RA within 45 days from Medicare's statement date, bill MAA directly.

- If Medicare has made payment, and there is a balance due from MAA, you must submit a HCFA-1500 claim form (with the "XO" indicator in field 19). Bill only those lines Medicare paid. Do not submit paid lines with denied lines. This could cause a delay in payment.

- If Medicare denies the service, but MAA covers it, bill MAA on a HCFA-1500 claim form. **Do not list an "XO" indicator in field 19**. Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment.

- If Medicare denies a service that requires prior authorization by MAA, MAA waives the ***prior*** authorization requirement. However, providers must obtain an authorization number from MAA after the service has been performed (see Section I). Authorization or denial of your request will be based upon medical necessary.

> **Note:**
>
> ✓ **Medicare/Medicaid billing claims must be received by MAA within six (6) months of Medicare's EOMB paid date.**
> ✓ **A Medicare Remittance Notice or EOMB must be attached to each claim.**

Payment Methodology – Part B

- MMIS compares MAA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no MAA allowed amount, MMIS uses Medicare's allowed amount.)

- Medicare's payment is deducted from the amount selected above.

- If there is *no* balance due, the claim is denied because Medicare's payment exceeds MAA's allowable.

- If there *is* a balance due, payment is made towards the deductible and/or coinsurance up to MAA's maximum allowable.

MAA does not make direct payments to clients to cover the deductible and/or coinsurance amount of Medicare Part B. MAA *may* pay these costs to the provider on behalf of the client when:

- The provider **accepts** assignment; and

- The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare or Medicaid's allowed amount, whichever is less.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, EPSDT, First Steps, and Medicare, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To:** Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her Social Security Number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payer of last resort.

11a. **Insured's Date of Birth**: When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?**: Indicate *yes* or *no*. If yes, you should have completed *fields 9a. – d*.

17. **Name of Referring Physician or Other Source**: When applicable, enter the referring physician or Primary Care Case Manager (PCCM) name. This field *must* be completed for consultations or for referred laboratory or radiology services (or any other services indicated in your billing instructions as requiring a referral source).

17a. I.D. Number of Referring Physician: When applicable, 1) enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the PCCM referred the service, enter his/her seven-digit identification number here.

Find a provider number by:

- Accessing the Provider Number Reference web site at: http://pnrmaa.dshs.wa.gov; or
- Calling MAA toll free at: 1-800-562-6188.

For non-Medicaid referring providers, enter the provider's name in Field 17 and "8900946" in field 17a. This "standard" number is to be used ONLY for non-Medicaid-referring providers. It is not specific to a provider.

19. **Reserved For Local Use**: When applicable, enter indicator **B**, *Baby on Parent's PIC*, or other comments necessary to process the claim.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report).

23. **Prior Authorization Number**: When applicable. If the service or equipment you are billing for requires authorization, enter the nine-digit number assigned to you. Only one authorization number is allowed per claim.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., July 4, 2005 = 070405).

24B. **Place of Service**: Required. See pages J.2 and J.3 for correct POS codes. These are the only appropriate place of service codes.

24C. **Type of Service**: Not required.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate procedure code for the services being billed. **Modifier**: When appropriate enter a modifier.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM, or relate each line item to *field 21* by entering a 1, 2, 3, or 4.

24F. **$ Charges**: Required. Enter your usual and customary charges for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not include sales tax. Sales tax is automatically calculated by the system and included in your remittance amount.

24G. **Days or Units**: Required. Enter the total number of days or units for each line. These figures must be whole units.

24H. **EPSDT Family Plan**: When billing the department for one of the EPSDT screening procedure codes, enter an **X** in this field.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: This is any nine-digit alphanumeric entry ***that you may use as your internal reference number***. *You* create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

32. **Name and Address of Facility Where Services Were Rendered**: When required, put the name of the facility where services were performed.

33. **Physician's Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Put the Name, *Address,* and *Phone #* on all claim forms.

P.I.N.:

This is the seven-digit number assigned to you by MAA for:

A. An individual practitioner (solo practice); **or**
B. An identification number for individuals only when they are part of a group practice (see below).

Group:

This is the seven-digit number assigned by MAA to a provider group that identifies the entity (e.g., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number.

☞ **Note:** Certain group numbers may require a PIN number, in addition to the group number, in order to identify the performing provider.

How to Complete the HCFA-1500 Claim Form for Medicare Part B/Medicaid Crossovers

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!

General Guidelines:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

- **Do not use red ink pens, highlighters, "post-it notes," or stickers** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. Make sure ink is not too light or faded.

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

The HCFA-1500 claim form, used for Medicare/Medicaid Benefits Coordination, cannot be billed electronically.

FIELD DESCRIPTION

1a. **Insured's I.D. No.**: Required. Enter the MAA Patient Identification Code (PIC). This information is obtained from the client's current monthly Medical Identification card and consists of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- ✓ Mary C. Johnson's PIC looks like this: MC010633JOHNSB.
- ✓ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*).

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24.* ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4.* Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payor of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3.*

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. **If 11d. is left blank, the claim may be processed and denied in error.**

19. **Reserved For Local Use - Required. When Medicare allows services, enter *XO* to indicate this is a crossover claim.**

22. **Medicaid Resubmission**: When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., July 4, 2005 = 070405). **Do not use slashes, dashes, or hyphens to separate month, day, or year (MMDDYY).**

24B. **Place of Service**: Required. See pages J.2 and J.3 for correct POS codes. These are the only appropriate place of service codes.

24C. **Type of Service**: Not Required.

24D. **Procedures, Services or Supplies HCPCS**: Required. Enter the appropriate Centers for Medicare and Medicaid (CMS) (formerly known as HCFA) Common Procedure Coding System (HCPCS) procedure code for the services being billed.
MODIFIER: When appropriate enter a modifier.

24E. **Diagnosis Code**: Enter appropriate diagnosis code for condition.

24F. **$ Charges**: Required**. Enter the amount you billed Medicare for the service performed.** If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

24G. **Days or Units**: Required. Enter the number of units billed and paid for by Medicare.

24K. **Reserved for Local Use**: Required. Use this field to show Medicare allowed charges. Enter the Medicare allowed charge on each detail line of the claim (see sample).

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

27. **Accept Assignment**: ***Required***. Check **yes.**

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: Required. Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**

30. **Balance Due**: Required. Enter the Medicare Total Payment. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**

32. **Name and Address of Facility Where Services Are Rendered**: Required. Enter Medicare Statement Date ***and*** any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required.

P.I.N. #: Required. Enter the individual provider number assigned to you by MAA.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): MJ070160SMITHA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, MARY, J

3. PATIENT'S BIRTH DATE MM DD YY: 07 01 60 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 5555 NEVERENDING ROAD

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYWHERE STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 461.0
2. 465.0
3. .
4. .

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11	01	05	11	01	05	11		99201		1, 2	5000	1				
2																
3																
4																
5																
6																

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 5000

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 5000

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

JAMES W WILLIAMS 1500 N MADISON
ANYTOWN WA 98926 (360) 777-8888

PIN# GRP# 1234567

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

Medicare Crossover

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): MJ070160SMITHA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, MARY, J

3. PATIENT'S BIRTH DATE MM DD YY: 07 01 60 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 5555 NEVERENDING ROAD

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYWHERE STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: XO

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 461.0
2. 465.0
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	11	01	05	11	01	05	11		99201		1, 2	5000	1				
2																	
3																	
4																	
5																	
6																	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 5000

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 5000

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

JAMES W WILLIAMS 1500 N MADISON
ANYTOWN WA 98926 (360) 777-8888

PIN# GRP# 1234567

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500